96-61

CANCER INSURANCE AND THE ELDERLY

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON
ANTITRUST, MONOPOLY AND BUSINESS RIGHTS

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

AND

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

CANCER INSURANCE PRACTICES

MARCH 20, 1980

Serial No. 96–61

Printed for the use of the Committee on the Judiciary and
Select Committee on Aging

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CANCER INSURANCE AND THE ELDERLY

THURSDAY, MARCH 20, 1980

U.S. SENATE,
SUBCOMMITTEE ON ANTITRUST,
MONOPOLY AND BUSINESS RIGHTS,
COMMITTEE ON THE JUDICIARY,
AND THE HOUSE SELECT COMMITTEE ON AGING,
Washington, D.C.

The committees met, pursuant to notice, at 10 a.m., in room 6226, Dirksen Senate Office Building, Senator Birch Bayh (acting chairman) presiding.

Present: Senator Bayh and Congressmen Pepper, Drinan, Marks, Bonker, Downey, Oakar, and Gudger.

Also present from the Senate subcommittee staff: Herman Schwartz, chief counsel; Stewart Kemp, special counsel; James Phillips, chief investigator; Peter Chumbris, minority chief counsel; Joseph Lanham, minority chief economist, and Marilyn Falksen, chief clerk.

Also present from the House Select Committee on Aging: Charles Edwards, chief of staff; Val Halamandaris, senior counsel; David Holton, chief investigator; Kathleen Gardner, professional staff member; Marie Brown, executive secretary; Nancy Smythe, investigative researcher; Molly Clark, secretary; and Dr. Walter A. Guntharp, minority staff director.

OPENING STATEMENT OF SENATOR BAYH

Senator BAYH [acting chairman, presiding]. The hearing will come to order, if you please.

I have mixed feelings about being here at this particular moment, as a member of this subcommittee. Of course, I am deeply involved, along with Senator Metzenbaum, the chairman, in what we are doing.

We are privileged to join and welcome the House Select Committee on Aging to this joint hearing, which I believe is of extreme importance to the country and a lot of folks who are in the process of being ripped off at a time in their lives when it is particularly unconscionable.

Senator Metzenbaum has been very concerned about this, and had looked forward to having a chance to be with us to chair these hearings. Unfortunately, he was smitten overnight by a bug and found out that Senators are human, not necessarily House Members, but Senate Members. [Laughter.] He asked me to at least welcome the Members of the House and to get the committee hearing started, and then I have other hearings that I am supposed to be presiding over right now. I think Congressman Pepper is familiar with this side of the House, and can serve in a dual capacity and chair in the absence of Senator Metzenbaum and myself.

I would like to ask, if there is no objection, that Mr. Kemp, Senator Metzenbaum's special counsel, be permitted to read the statement of the Senator in his absence.

I just might say one word. I think the mission that calls us here is extremely important. We don't need to say a whole lot about the critical nature of cancer, the efforts this country is making to try to find the answer to that riddle of why close to 300,000 Americans are taken prematurely. We need to declare war against cancer and demand unconditional surrender.

I cannot think of a more unscrupulous group of folks than those who prey on the fear that Americans have that they might be in that group of one of three who in their lifetime would contract cancer. There is a reason to be fearful, and because of that concern, I think it is even more important that we in the Congress see that certain groups of citizens are not permitted to prey on those who are fearful for cancer and sell them insurance policies which really don't do the job that needs to be done. So, I think the mission of this hearing is a very salutary one. I just wish that I had not been previously committed to preside at an appropriations hearing.

If I might yield to my friend from Florida, who has been one of the leaders in the area of attempting to strike a death blow to cancer and find the answer to this problem. He has also painfully experienced relatively recently what this disease means personally. Prior to that time he was already one of the most sensitive Members of Congress as far as this problem is concerned. He and other members of the committee, of course, have performed very worthwhile services to the Congress and to the country in the way in which they have been delving into the multitude of problems that confront our senior citizens. So, I just wish I could be here with you.

OPENING STATEMENT OF REPRESENTATIVE PEPPER

Mr. Pepper. Senator Bayh, before you leave, if I may, first let me express the very deep appreciation of the House Select Committee on Aging to Senator Metzenbaum and to you and all the members of your subcommittee for making it possible for us to have this joint hearing upon what you have fittingly described as a very critical subject.

Senator Bayh and I both, in a very painful way, have had personal experience with the tragedy of cancer. We know what a monster it is. We both share the desire of all of our people to protect against approaches that are not proper and not in a spirit in which an enterprise should be carried on in this country, to prey upon the fears of people to induce them to do something that they economically should not do.

Senator, before you leave, I would like to file with you, on behalf of the Subcommittee on Antitrust, Monopoly and Business Rights of the Senate, a report which is ready for issuance by the House Select Committee on Aging. This is a study we have made over a considerable period of time with respect to the advertising and the practices involved in the sale of cancer insurance policies.

After the Senator has left and after the statement of Senator Metzenbaum has been read, I will summarize this 300-page report. That report is based upon a great deal of study by our committee. We had a number of hearings and heard a number of knowledgeable witnesses testify on this subject.

We hope this report will be of some help in evaluating the cancer insurance program that is conducted by some insurance companies in this country.

Thank you very much.

[The House report referred to above is on file with the committee.]

Senator BAYH. Again, I apologize for the necessity of being elsewhere, but I leave it in good hands.

Mr. PEPPER. Thank you, Senator Bayh.

Senator BAYH. Thank you.

Mr. PEPPER [acting chairman, presiding]. Now we will hear the statement of Senator Metzenbaum, please.

OPENING STATEMENT OF SENATOR METZENBAUM; PRESENTED BY STEWART KEMP

Mr. KEMP. Today the Subcommittee on Antitrust, Monopoly and Business Rights continues its examination of the operation of the insurance business under the McCarran-Ferguson Act. We will focus this morning on cancer insurance, a form of limited health insurance which pays benefits if a person contracts cancer.

I am very pleased that the House Select Committee on Aging is joining the Antitrust Subcommittee in this hearing and I wish to extend a very warm welcome to Chairman Pepper. The Committee on Aging has done excellent work in the area of health insurance sold to the elderly. The Aging Committee has recently undertaken an extensive examination of cancer insurance, and a very thorough report on this subject is being released today. I understand that Chairman Pepper will describe his committee's report in his opening remarks.

The staff of the Subcommittee on Antitrust, Monopoly and Business Rights has also conducted an in-depth examination of cancer insurance, and has come up with some very disturbing findings.

One: Sales techniques are based on fear and deception;

Two: The scope of coverage in most policies is sharply limited;

Three: The economic value of this insurance, as measured by the proportion of premiums returned as benefits, is as low as I have ever seen for any kind of insurance; and

Four: Claims practices are in many instances scandalous.

Let us look at sales. Does an automobile insurance company sell you a policy by stirring up fears of having an accident? Do sellers of comprehensive health coverage conjure up dire specters of debilitating illness? Of course not. But this is how cancer insurance is sold. Over on my right are enlargements of selling materials used by American Income Life Insurance Co., a major seller of cancer insurance. What do these messages convey about the worth of the policies? Nothing. Their only purpose is to arouse fear. "Cancer can happen to you." A list of famous persons to whom cancer happened.

The sellers of this coverage also rely on exaggerations of policy benefits to snare the unwary consumer. Union Fidelity, for example, touts its leading plans on the basis that they provide up to $150,000, even $200,000, in total coverage. These figures are based on the possibility of very lengthy stays in the hospital, up to 20 months or longer. In fact, fewer than 1 percent of cancer patients stay in the hospital longer than 90 days. Union Fidelity's average benefit per claimant is about $1,400. Other companies warn of "staggering" and "astronomical" cancer costs averaging "between $30,000—$40,000" per victim. But average claim payments are only $1,000 to $1,500 per recipient.

Our investigation has also discovered that companies systematically fail to disclose policy limitations and exclusions. Common costs of cancer treatment like diagnostic procedures, chemotherapy, radiation treatment and even surgery are not covered or are subject to unrealistically low ceilings. Broad preexisting condition exclusions often deprive insured cancer victims of any coverage whatsoever. And pathological diagnosis of cancer is generally required even if a doctor's clinical assessment is clear. Ironically, cancer insurers have been known to demand biopsies of cancerous tissue even where the procedure would be very harmful to the patient.

As a result of all the limitations, cancer policies typically pay only about 30 percent of the costs of cancer care—this is a stark contrast with the glowing promises of security in the face of the dread disease.

It's the old story again—what the big print gives, the fine print takes away. Only the big print is in the sales pitch, while the fine print is in the legal contract—the policy.

The limited economic value of cancer insurance policies is further reflected in the low loss ratios. The loss ratio represents the proportion of premiums returned as benefits and is the fundamental gage of economic worth. The chart on my right shows the 1977 loss ratios for all health insurance, and specifically for cancer coverage. These data were compiled by the General Accounting Office. They show that major health insurers pay back 80 to 90 cents on the dollar. But cancer insurance shows a range of only 19 to 70 cents. This means that American Family retains about six times as much of the consumer's dollar as Blue Cross-Blue Shield. Union Fidelity—which is in the 19-cents range—keeps a remarkable eight times as much.

With margins like these, the companies might be expected to be liberal on those rare occasions when a policyholder actually does contract cancer; not so. The subcommittee staff found numerous instances of refusals to pay valid claims. In one case, a man was refused coverage by American Family for private hospitalization, because he was also confined later in a Veterans' Administration hospital.

Incidentally, the company refused payment in this case even though the man's policy had no such exclusion and the agent had promised that the policy always paid off regardless of other benefits.

In still another case, the Mid-South Insurance Co. refused to pay a skin-cancer claim which arose from a mole. The company claimed a preexisting condition. Incredibly, they said that since the claimant had had the mole for 20 years or longer, he must have had cancer when he took out the policy. We will hear from these individuals, or their representatives, later this morning.

In view of the record, what have State insurance regulators done about it? Here we find the same pattern as with other types of insurance—a handful of progressive regulators who have taken effective action, but most have done nothing. Five States—Connecticut, Massachusetts, New Hampshire, New Jersey, and New York—have banned its sale altogether or sharply curtailed it. Several others have established regulatory standards. But in most States it's business as usual—and consumers remain unprotected against deceptive sales practices, excessive premiums, and unfair claim practices.

Massachusetts has been especially vigorous in documenting problems in this area. Former Commissioner James Stone initiated market conduct audits of several leading cancer insurers when he was in office. His staff was in the process of writing a full report on their recommendations when he left office. He has provided Chairman Pepper and me with a completed draft of that report. Our staffs have reviewed it and found it to be extremely well done. We will include it in the record of this hearing.

[The report and an accompanying letter appear in the appendix.]

I am also pleased to have with us the former director of field audit for the Massachusetts Insurance Department and a prinicipal author of the market conduct examinations begun by Commissioner Stone.

These two individuals, with several others, documented sales and marketing practices of sellers of these products more thoroughly than has ever been done elsewhere, and found literally scores of violations of State law by these companies.

I am also very pleased to have with us Herbert Denenberg, former Pennsylvania Commissioner of Insurance. Long an articulate spokesman for progressive insurance regulation, Mr. Denenberg has distinguished himself both in office and out.

To represent the industry, the chief executive officers of Union Fidelity and American Family Life have also been invited to testify. The names of these two companies have come up more frequently than any others in the course of our investigations. American Family, as the largest seller of cancer insurance in the country, is obviously crucial.

John B. Amos, chairman of the board of American Family, was invited to appear before this committee, but has advised me that he will not appear voluntarily.

Mr. John Cooney, president of Union Fidelity, was willing to testify but could not appear today because of a prior commitment.

This completes Senator Metzenbaum's opening statement.

Mr. PEPPER. Thank you very much, Mr. Kemp, for your reading of Senator Metzenbaum's very able statement. We commend the Senator and your subcommittee for the excellent inquiry you have made into this critical field.

As I said before, we are immensely pleased that we can have a joint hearing on this subject by our two committees who are very much interested in this subject.

I would like very much to give a little summary of the report. It is about 300 pages. We have just released it to Senator Bayh, on behalf of the Subcommittee on Antitrust, Monopoly and Business Rights of the Senate Judiciary Committee. Copies will be made available to the press and to interested parties here by our staff.

SUMMARY OF HOUSE SELECT COMMITTEE ON AGING REPORT, PRESENTED BY CONGRESSMAN PEPPER

Mr. PEPPER. We found that in order to create a market for their product, cancer insurers commonly exaggerate statistics. For example:

One: One cancer company often tells its prospective customers that two out of three families on their street, or one out of every four of us will be affected by cancer. In fact, actual statistics are more heartening. More accurately, one in every 280 Americans will contract cancer in any given year.

Two: Many cancer brochures we examined belabor the costs of cancer, citing horrible examples of people who had to pay $100,000 or more over a lifetime. To be sure, cancer is expensive and serious, but average lifetime costs are closer to $10,000.

We found that most cancer sellers kindle the fears we all have of cancer. For example:

One: Shortly after the news of Three Mile Island broke, cancer insurance agents were busy soliciting business in the Harrisburg, Pa., vicinity.

Two: Brochures assist agents in heightening fears. One policy lists the names of famous people who have died of cancer, juxtaposed with the words, "What happened to them can happen to you." Others, using scarlet red backgrounds, depict gnarled cell growths—supposedly cancer.

Agents selling cancer insurance often try to persuade their customers that their existing insurance is not adequate. One company goes as far as to assert, "You have no insurance. Your doctor gets your insurance. You just pay the bills." The fact is, major medical plans provide reasonable protection against cancer as well as every other disease. Senior citizens are even better protected in that they have medicare and generally one or more supplementary policies, and in some cases, medicaid benefits. Other agents do not mention that the purchase of a cancer policy may result in reduced benefits by some major medical plans, such as Blue Cross-Blue Shield. That means that some companies will not pay a claim if another company pays the same claim.

Some cancer insurance companies promise much but deliver little. Many companies promise $150,000 or even $250,000 in the event that cancer strikes. In other cases, they say they will pay 50 percent of all the costs of cancer. In fact, few will ever collect anything at all under the policy and those who do will receive about $1,200 per claim. No one will ever collect $150,000, much less $250,000. To collect these amounts, a policyholder would have to be hospitalized continuously for more than a year.

Even though most cancer costs are incurred outside the hospital, cancer policies are keyed to the services rendered during hospitalization.

Many policies are written in obtuse legal jargon with generous 167-word sentences designed to confuse the best Philadelphia lawyer.

The policies will pay only after there has been a pathological confirmation. Sometimes it is impossible to collect the confirming tissue sample without risking the life of the cancer patient. For example, in

Washington State, the body of a deceased cancer victim was exhumed and a pathology report filed before payment was made to the person's estate.

Cancer policies will not pay for cancer-related complications. For example, a mastectomy would be covered under the cancer policy but the followup reconstructive surgery would not be. Or a broken leg which results from X-ray radiation also would not be compensable.

We found that even with these restrictive exclusions and limitations in their policies, many cancer firms fail to pay legitimate claims. Audits by Price Waterhouse and Coopers & Lybrand found two major companies improperly denied some 20 percent of the claims submitted to them.

Not surprisingly, we found extremely high profits for many cancer insurance firms. GAO informed the committee that most cancer insurers return about 40 percent of the premium dollar, and in one case, as little as 19 percent of the premium dollar to their insured in the form of claims. This means that the firms are keeping 60 to 80 cents on each dollar in profits and expenses. By contrast, all health insurers returned an average of 80 cents on the dollar to their customers last year.

As Mr. Kemp pointed out, on the left here is a list of famous people who died of cancer, who are emphasized in cancer insurance sales pitches.

Over here on the right is a chart first showing companies selling general health insurance which, of course, would include cancer. The payment back to the insured; that is, the company's loss ratio is 91 percent by Blue Cross, 87 percent by Blue Shield, 92 percent by Occidental, 90 percent by John Hancock, 89 percent by Aetna, 89 percent by Equitable, 88 percent by Travelers, 87 percent by Allstate, and 86 percent by Connecticut General. The national average of all those companies in the payment of general medical claims is 80 percent.

Then, you see down below are the companies that are selling cancer insurance. It goes from Mutual of Omaha, which on the average pays back 70 cents in claims out of $1 received in premiums down to Union Fidelity which pays 19 percent. Just for the record, Mutual of Omaha pays 70 percent; ITT Life, 61 percent; Lone Star Life, 55 percent; American Income, 49; Colonial Life, 49; Washington National, 48; American Family, 43; Liberty National, 26, and Union Fidelity, I believe, that is 19.

So, our major conclusions are these. One: Cancer insurance policies have limited economic value; Two: Many cancer insurance firms employ fear tactics to sell their product; and Three: Policyholders, and particularly the elderly, are better off if they would invest the same amount of money in a policy which pays regardless of the cause of the health costs. In other words, a general health policy.

These are our recommendations, in our report.

One: The Congress should require that policies sold to the elderly in supplementation of medicare are broad in scope and not limited to providing coverage against a single dread disease.

Two: We ask the States to review their own laws with an eye to providing protections for all Americans against the abuses disclosed.

Three: Finally, we ask the Congress to act to close the loophole which permits policies to be sold by mail in States where these same policies cannot be sold by agents.

It is obvious that if somebody sells me a policy by mail in Florida, which is, let us say, a company existing in the District of Columbia, and I find that they have misrepresented their policy or they don't pay the claims that they promised, or there is some other reason for me to sue, the only thing I can do is to come up to the District of Columbia, get a lawyer here and the like and bring my suit in the District of Columbia.

The National Association of Insurance Commissioners has asked Congress to enact a law requiring that all policies sold in supplementation of medicare be first filed with and approved by the commissioner of insurance in the respective State before such policies could be sold through the mail in that State. That way, the insurance commissioners would have an opportunity to examine the fairness of the policy, and if they wished to, they could look into the operations and sales practices of the company and the like. They could then designate somebody in the State upon whom service can be made in case there is a claim to be filed by somebody who has been sold that insurance, living in that State.

So, we respectfully draw the attention of your subcommittee to these findings and these recommendations of our committee. Mr. Chairman, we commend this report to you. We plan to send it to the appropriate committees in the House and to the State insurance commissioners. We hope that legislation will follow at both the State and Federal levels.

Now I would like to give my colleagues on the House committee, or the esteemed members of that committee, an opportunity to make any statement they would care to make.

First, Mr. Marks.

OPENING STATEMENT OF REPRESENTATIVE MARKS

Mr. MARKS. Thank you, Mr. Chairman.

Mr. Chairman, I am pleased to be able to participate in today's hearing on the issue of cancer insurance. I believe the fact that we are holding this hearing as a joint hearing with the Senate Subcommittee on Antitrust emphasizes the importance of this investigation into the sale of cancer insurance.

The 1978 report on the sale of health insurance to the elderly by the House Select Committee on Aging brought into the open many of the fraudulent practices used by some insurance agents. This hearing, and the report on cancer insurance which we are releasing today, are in response to concerns which arose during that 1978 investigation. I would like to commend the fine work done by the Aging Committee staff on this report. That is really an understatement. It was absolutely superb.

This new report, entitled "Cancer Insurance: Exploiting Fear for Profit," spotlights many of the questionable sales practices of some insurance companies. This report makes a number of recommendations about how individuals, particularly the elderly, should be further protected against unscrupulous insurance companies and their agents.

This investigation should absolutely not be viewed, I would like to emphasize that, absolutely not be viewed, however, as an attack on the entire insurance industry. Our sole purpose here is to look into the sale of cancer insurance, which 49 of the top 50 insurance companies in this Nation do not even consider worth marketing themselves.

I am not convinced that the Congress should act, at this time, to ban the sale of cancer insurance. The McCarran-Ferguson Act specifically leaves the regulation of the insurance industry to the States. I feel that this arrangement has worked, so presently I do not see any need to deviate from the intent of this act. I do believe, however, that State insurance commissioners should review their regulation of cancer insurance to insure against the sale of worthless or duplicative policies.

The Congress should take whatever steps are necessary to assure that the States have the ability to regulate these policies as they see fit.

State insurance commissioners have asked that we specifically assist them in their efforts to regulate the sale of mail order insurance.

In closing, I would add that this report reinforces my belief in the need to pass H.R. 2602, the Senior Citizens' Health Insurance Reform Act of 1979, as introduced by our most dedicated chairman, Claude Pepper. The voluntary certification of health insurance policies would provide, I think, consumers with some measure of assurance that they are not buying a worthless or fraudulent health insurance policy. Thank you, Mr. Chairman.

Mr. PEPPER. Thank you very much, Mr. Marks.

Mr. Bonker, of Washington.

OPENING STATEMENT OF REPRESENTATIVE BONKER

Mr. BONKER. Thank you, Mr. Chairman.

I would like to join Mr. Marks in commending you for your leadership in this area, and particularly the staff. I think that this is an excellent report with its revelations about abuses in insurance policies, particularly those that relate to dread disease. I think it is going to be very helpful to the Congress and should serve as a foundation upon which we can build legislation to deal more effectively with this problem.

The Washington Post had an article this morning on this subject, relating to the publication that you revealed this morning, Mr. Chairman. When you cite the statistics up there, particularly those of Union Fidelity with only a 19-percent return, the Post notes that that is much less than the gamblers take away from Nevada slot machines. They usually have a return rate of about 70 cents on every dollar. So, I think that we can at least match the odds that are in Las Vegas.

The committee had some hearings in my State last year, Mr. Chairman, of which you are aware. The purpose of the hearing was to look at problems involving nursing home care in the sense that medicare patients were not obtaining the benefits to which they were entitled, because the nursing homes were not participating in the program. What astonished me is that virtually every senior citizen who appeared before the committee complained about this problem of insurance policies with its misleading information which had them purchasing policies only to find out later that these policies only duplicate what they were already entitled to under medicare.

For example, many times senior citizens would move from a hospital to a nursing home thinking they were covered fully through an insurance policy to discover that that so-called supplemental insurance only duplicated what they were already being provided under medicare. Supplemental insurance is a problem because it duplicates what the Government is already providing and more seriously it misleads senior citizens into thinking they have full coverage.

The cancer insurance report contains a survey, Mr. Chairman, of the insurance commissioners, which is quite revealing. On page 166, the questionnaire which you sent out to the insurance commissioners posed this question: "In your experience, have you ever found that companies selling these products employ fear tactics to promote their policies?"

Keep in mind that the insurance commissioners are probably more aware than anyone else of abuses that take place. Of the 42 who responded, 36 said yes, and only 6 said no.

Then, you asked, "Do you agree that dread disease policies have very limited economic value? Again, of the number who responded, 26 said yes, and 14, no.

Then, finally, "Do you agree that most people would be better off if they improved their comprehensive coverage as opposed to buying a single disease policy?" And, of those who responded, 35 said yes.

Last year, I sent out another questionnaire to the insurance commissioners in attempting to find a legislative remedy. I posed this question: "Would you support the enactment of language which would require mail order supplementary policies to be filed with the commissioner before being sold in the State?" At that time, of 47 respondents 38 said yes.

The dilemma that we in the Congress face, and to which Mr. Marks refers, is: do we proceed with some kind of legislative action to deal with this problem or do we rely on State insurance commissioners, who are the proper authorities within each State, to address this problem?

My own feeling is that State insurance commissioners are too cozy with the insurance companies they regulate. They have not been the active advocates of the consumer, as it relates to these insurance policies. In the State of Washington, we have a fine insurance commissioner. I spent an afternoon with him on this problem. I asked him if he had an enforcement division. He said, yes, that he did. He also acknowledged that there were widespread abuses which we are revealing today in this report. I said, "How many times have you taken enforcement action against either an insurance company or an insurance salesman?"

He said, "There has never been any enforcement action against either." I said, "Why?" He said, "Because senior citizens or other victims do not bring claims to our office for legal action."

Whether this is because the victims are intimidated or they don't know that service is there, I don't know. I did ask the insurance commissioner what he was doing. He was very proud to tell me about the Shawbuck program, an educational program where he sends people all over the State to meet with senior citizen groups informing them of the potential dangers ahead in terms of insurance policies. That is no way to deal with this criminal act and the scandalous trend that we have had in insurance policies.

If insurance commissioners are not going to take effective action, and I think we in the Congress, particularly you, Mr. Chairman, have put them on notice, then Congress is going to have to.

Last, let me say we are only dealing with aspects of a larger problem. I personally feel that senior citizens should not have to buy supplemental insurance either on a comprehensive scale or for dread disease or any other particular area. We ought to fully expand medicare benefits so that senior citizens have the benefit of full health care coverage and not have to be victims of this policy scandal. So, I hope, Mr. Chairman, that this committee can renew its commitment to making sure that all senior citizens are forever free of the fear of astronomical health care costs and insurance fraud.

[The prepared statement of Representative Bonker follows:]

PREPARED STATEMENT OF REPRESENTATIVE DON BONKER

Chairmen Pepper and Metzenbaum, I am glad to be participating in this hearing today on Cancer Insurance and the Elderly. I commend Chairman Pepper for his leadership in issuing the report "Cancer Insurance: Exploiting Fear for Profit," which is the basis of today's hearing and I applaud the committee staff for their tremendous investigative efforts in conducting and compiling the research for this report.

The Aging Committee first learned of questionable practices in the sale of health insurance to the elderly in March 1978 during a long-term investigation of the health insurance industry and its impact on senior citizens. Since that time, my colleagues and I have received numerous calls and letters regarding questionable sales of health insurance policies to supplement medicare.

While the medicare program itself has failed to live up to its promises, many of the supplemental insurance programs intended to "fill the gaps" in coverage are an outright scandal. The committee estimates that 23 million elderly citizens purchase $4 billion worth of insurance each year that is fraudulent. Many of these policies by definition pay only for Medicare's copayments and deductibles. The problem is exacerbated by high pressure salesmen and by insurance companies who have targeted the elderly as easy marks for sales. Some companies return as little as 19 cents on the premium dollar back to their insured in the form of claims.

Among the most duplicative and unnecessary policies being sold today to senior citizens is the "dreaded disease" policy, particularly aimed at the sale of cancer insurance. Highly publicized fear and high pressure tactics have been extremely convincing to millions of Americans. Sadly enough, most insurance experts say it is wiser to buy a good medical-surgical policy that pays for any illness than for just one disease. Yet the report before us today states that approximately $4 billion in cancer insurance polices were sold in the U.S. during 1979, with an estimated 20 million policies in force today.

This report reflects my own sentiments. It is clear to me that dread disease policies, particularly cancer insurance policies, are merely a duplication of most major health plans and are useless. The best approach is clearly to purchase one comprehensive health insurance plan, avoiding duplication, confusion and potential abuse for our senior citizens.

Mr. PEPPER. Thank you, Mr. Bonker.

Every one of my colleagues here would be able to enlighten us immeasurably if we had the time to give them the full opportunity to say what they know and feel about this subject. We do have a number of witnesses, and I will ask my colleagues, as much as they can, to summarize their statements.

OPENING STATEMENT OF REPRESENTATIVE DOWNEY

Mr. DOWNEY. Thank you, Mr. Chairman. I want to congratulate you and once again, the staff, on really superb work. I disagree a little bit with Mr. Marks about the need for Federal regulation. I happen to believe that in this particular area we need it. I know you don't want to throw the baby out with the bath water, but it is clear to me, as Mr. Bonker stated, that the State regulators, some of whom are excellent, can't do the job because there are many of whom who are not.

Mr. Chairman, sometimes we get so involved in our work here in Washington, that we overlook the possibility that one of the millions we work to protect might be right on our own doorstep.

The report just released by my committee this morning is an indepth investigation of apparent fraud and abuse in the sale of cancer insurance. One of the companies which received attention by the committee was the Union Fidelity Insurance Co. This company was investigated by the Massachusetts Department of Insurance. Their conclusions were issued in a report in December 1978, citing over 210 violations of State law involving Union Fidelity's basic cancer policy and their cancer-rider policies.

Among the violations found were pictures of and misleading quotes from the late Senator Hubert Humphrey, who, in an interview, talked about the heavy financial burden of his brother's bout with cancer. The quotes from Senator Humphrey were used to emphasize the need for cancer insurance. Apparently, these tactics are very effective. I have just learned that Union Fidelity has a good customer in Mrs. Betty Shields, of Largo, Fla. Mrs. Shields is the mother of my press assistant, Dianne Ketchum, and until recently, she owned a home in my district, in Suffolk County, N.Y.

I suspect that Betty Shields is typical of the kind of customers targeted by cancer insurance companies. In 1977, she received an invitation to purchase a cancer policy in the mail. She wrote back to the company and accepted their offer purchasing a family policy to cover herself and her husband for $9.50 a month, or an annual fee of $114. In 1978, after her husband had a heart attack and died, Mrs. Shields converted her policy to an individual one, paying $89.60 annually. At this point, I must tell you that Mrs. Shields already had medicare coverage and a supplemental medical insurance policy from Blue Cross and Blue Shield. And, as we now know, her insurance already covered her not only for cancer, but for other diseases and illnesses as well.

To continue with the story, last year, just before Betty Shields turned 65, she received a birthday card from Union Fidelity listing her cancer policies and offering her a special once-in-a-lifetime life insurance policy of $1,000 at a very reasonable rate of $23.76 quarterly, or $95.04 for the year. She thought this was a bargain and snapped it up. Ironically, she felt that the $1,000 would cover her burial costs and that she wouldn't have to cause any further grief to her children and that is why she took the policy.

Six months later, a Union Fidelity salesman appeared to inform her that hospital costs for cancer patients had gone up and that she would be wise to increase her cancer coverage by adding cancer rider policies. This time she told him she would think about it.

Last week, just before her 66th birthday, Betty found in her mail a card which said, "Birthday greetings, specially for you, from John M. Cooney, President of Union Fidelity." The card announced, "This is a once-in-a-lifetime birthday offer," and directed her to take advantage of it by midnight the day before she turned 66. The offer was the same $1,000 life insurance, but this time, for less money, only $8.39 a month, instead of the $23.76 a quarter.

The only rub was the last year cost would have been $95 to Betty, and this new lower offer came to $100.68 for the year. Not much of a bargain.

Needless to say, because of this investigation we have scored at least one small victory for senior citizens. Today, Mrs. Shields sent her own special birthday greeting to Mr. Cooney canceling both her policies.

Mr. PEPPER. Thank you very much, Mr. Downey.

Ms. Oakar, from Ohio.

OPENING STATEMENT OF REPRESENTATIVE OAKAR

Ms. OAKAR. Thank you, Mr. Chairman.

I certainly want to associate myself with your remarks and the remarks or my distinguished Senator from Ohio, Senator Metzenbaum, and in particular the remarks of Mr. Bonker, because I certainly agree with him that we need a national policy on this particular issue. I certainly hope that everyone supports H.R. 2602.

I won't read my statement, but will ask your permission to put it in the record.

Mr. PEPPER. Without objection, so ordered.

Ms. OAKAR. I want to say for the record, I am somewhat embarrassed by our State commissioner's response from Ohio, who, in answer to your questions about tactics and economic value of these disease policies answered "no comment," to the majority of the questions. Now this is the State commissioner of Ohio, where there is blatant abuse. We have hundreds and hundreds of cases of this nature that my colleague from Ohio, Senator Metzenbaum, our committee and myself have heard about.

What we are dealing with essentially are the superslick cancer salesmen who deliberately hype their pitch to capitalize on the natural anxieties of older Americans. That is what it is all about. It is the worst kind of chicanery and I think if we want to have this continue. then the easy way to do it is answer, "No comment," as our State commissioner has answered in so many cases.

But we know that there are people like an Ohio woman who purchased 13 different policies, over a 2-year period, costing her more than $9,000, or 68 percent of her income. And, because of the chicanery and the deliberate hyping and the capitalizing on her own anxieties, she was led to believe that she needed this.

So, I look forward to our witnesses, Mr. Chairman. I think we need a national law because it is a fact that nothing is going to be done by the majority on the State level, unfortunately.

Mr. PEPPER. Thank you very much.

[The prepared statement of Representative Oakar follows:]

PREPARED STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Mr. Chairman and members of the subcommittee, I would like to thank you for the opportunity to present my views on the abuses in the sale of cancer insurance, especially as it pertains to our senior citizens. You are to be commended for your concern in this area and your initiative in holding this hearing.

As you may know, I am a member of the Select Committee on Aging, chaired by my distinguished colleague and friend, Senator Pepper, who is today releasing a report entitled "Cancer Insurance: Exploiting Fear for Profit." The problem of abuses in sales of insurance to the elderly is widespread. Senior citizens are often sold policies that are duplicative, unneeded, or extremely limited in their coverage. One of the most frequently sold of these policies is that which is marketed to pay for health expenses only in the event that the policy holder develops cancer, and then only for cancer-related expenses, many of which are already covered by medicare. Nevertheless, the fear tactics used by some insurance salesmen continue to promote sales of these policies, usually to people who don't understand them and often to those who can least afford them. Few people who purchase a cancer insurance policy ever develop cancer. Fewer still file a claim. Those who collect anything at all average about $1,000 in benefits. And those select few who collect a substantial sum of money frequently discover that the collection means that other insurance companies will reduce their payments proportionately.

Medicare coverage pays for only 38 percent of the health care costs of the elderly, and even with private insurance supplementing medicare coverage, the average out of pocket cost for those over 65 was $403 in 1976. Considering the fact that two-thirds of our senior citizens have at least one supplemental health insurance policy, with many having more than one, the total cost of health care is astronomical. Of this two-thirds, an estimated 40 percent have purchased bogus policies from unscrupulous insurance companies. The financial burden such policies place on an older person living on a fixed income is a travesty.

The House Select Committee on Aging has concluded that a disproportionate number of cancer insurance policies are sold to the elderly. Misrepresentations made by insurance salesmen have been found to include exaggerated statistics, phony testimonials, and false or misleading claims and promises. One problem is that insurance sold by mail, particularly mail-order cancer insurance, is essentially beyond the reach of State regulators. Compounding this problem, companies selling cancer insurance policies often exercise little control over their own agents. Troubling also is the fact that while most cancer costs are incurred outside the hospital, cancer policies are geared to pay for cancer costs only when the individual is in the hospital. Furthermore, cancer brings on related medical problems, and many cancer insurance policy do not pay for the costs of these complications. Some cancer policies will pay only for a certain time period after cancer is diagnosed—a fact which is not always made known to the policyholder.

Cancer insurance is a product which has a very limited economic value. It is banned outright in five States (Massachusetts, New York, New Jersey, Connecticut, and New Hampshire), and all but banned in eight other States by virtue of minimum loss ratio requirements that are so high that fewer cancer insurers can comply with them.

The elderly are particularly vulnerable to fast-talking salesmen. Numerous examples can be cited from my own State alone. One Ohio woman bought 13 different policies over a two-year period costing her more than $9,000 or 68 percent of her income.

The information given to potential purchasers of supplementary insurance does not always appear to be what it is. In 1977 the Ohio Better Business Bureau received a complaint about a questionable insurance solicitation which was received through the mail. One couldn't be sure it was insurance however, because neither the company nor its address was included on the booklet, "A Pocket Guide to Medicare". Some of the literature bore a marked resemblance to a Government medicare publication. This insurance pitch used mediocre data and underscored the shortcomings of medicare, presumably to frighten the elderly. The package was sent through the mail by a Dayton, Ohio, agent for a large insurance company. The agent sells a product called "Eldercare," which he describes not as insurance but as a "supplement to medicare." Later the agent said that when the potential client called for promised "further information" at "no cost" and "no obligation" he or she would be told that the company was selling insurance.

Traditionally, the regulation of insurance is a State prerogative, however there are some areas in which Congress could, and perhaps should, intervene. Supplementary insurance policies sold to the elderly might be required to provide broad range coverage. One of the major conclusions of the report by the Select Committee on Aging is that policyholders are better off spending the same amount of money to buy a wrap-around policy which provides protection for all disease or accident caused health care costs, rather than buying policies for particular diseases. Second, some means should be provided by which State governments regulate mail order insurance coming into their State.

The report published by the Select Committee on Aging is impressive in its collection of data, its analysis of the issues, and the recommendations and conclusions reached. It is my sincere hope that this report, and the testimony presented at these hearings, will result in concrete reforms in the regulation of cancer insurance.

Mr. PEPPER. Mr. Gudger of North Carolina.

OPENING STATEMENT OF REPRESENTATIVE GUDGER

Mr. GUDGER. Mr. Chairman, thank you for the opportunity to commend you and the Senate Judiciary Committee's Subcommittee on Antitrust, Monopoly and Business Rights for undertaking these important hearings.

I think whenever 38 insurance commissioners appeal to the Congress for some assistance in closing a loophole in regulation of the sale of insurance by mail, then we must realize that action by the Congress is fully justified.

On the other hand, I think we are all mindful of our obligation not to encroach on the traditional prerogative of the State to regulate insurance. I am sure that encroachment will not be the result of our action, but rather that we will be developing here a program and plan to supplement State action and hopefully provide some direction to the States by coordinating information and recommending actions.

I commend you for your opening remarks and the committee for undertaking this important hearing. Thank you.

Mr. PEPPER. Thank you very much.

Is there anything from any Member of the Senate?

Mr. CHUMBRIS. Mr. Chairman, on behalf of Senator Thurmond, I ask unanimous consent that an opening statement may be placed in the record.

Mr. PEPPER. Without objection, so ordered.

Mr. CHUMBRIS. Also, certain written questions that he may have. We can present them to the witnesses and they may respond to them in writing.

Mr. PEPPER. Very well, sir. Without objection, so ordered.

Mr. CHUMBRIS. Thank you, Mr. Chairman.

Mr. PEPPER. Any other contribution from any other Senator? [No response.]

Thank you very much.

I guess we are now prepared to call our witnesses. We appreciate very much your waiting for us today as we started a little late.

May I call now to the witness table the following people: Mr. H. W. "Jack" Sturgeon, of Arkansas; Mrs. Sigmund Sobiesiak, of Pennsylvania; Mr. Robert Linn, of California; Mr. Steven Schmidley, of North Carolina; Dr. Dan Kenshalo, of Florida; and Mr. Marc H. Botzin, of Washington.

Please take your seats.

Mr. PEPPER. First, I will recognize Mr. Phillips, a member of the staff of the Senate committee, who will inquire of the witnesses on behalf of Senator Metzenbaum. We are so sorry to hear that Senator Metzenbaum is temporarily indisposed today. We do appreciate the fact we have been permitted to go ahead with this hearing.

Thank you. Mr. Phillips!

Mr. PHILLIPS. Our first witness on the consumer panel will be Mr. Robert Linn.

STATEMENT OF ROBERT LINN, PALO ALTO, CALIF.

Mr. LINN. Thank you.

Mr. Chairman, my name is Robert Linn. I want to address myself to sales tactics used, and second, to methods of settling claims with a company called American Family Life Assurance Co., Columbus, Ga.

I reside in Palo Alto, Calif. I am the national sales manager of an electronics firm in Mountain View, Calif. For 12 years prior to this, I have been a vice president of a company that manufactures carpeting with a sales volume of over $100 million a year. I was retired for a period of 12 years, from the time I was 50 to the time I was 62.

I consider myself an informed, sophisticated, and intelligent businessman. However, I have been taken in by the deceptive sales tactics of American Family Life Assurance Co. of Columbus, Ga. I am certain that there are hundreds of people with more or less business experience than I have who have been and are also fooled.

The very real danger to people who purchase cancer insurance policies from American Family Life Assurance Co., lies in the fact that the possession of a cancer policy gives the owner a false sense of security and prevents the acquisition of other insurance that can provide real financial protection against the medical expenses of cancer.

The American Family policy, in my opinion, based on my experience with the company, is woefully inadequate in meeting the medical expenses of cancer with the benefits the policy provides. The policy was presented to me as all-inclusive protection against the medical costs of cancer with the major provisions—this was in 1970—of a $7,500 hospital benefit, $1,500 surgical benefit, $500 X-ray, $250 nursing, $350 anesthesia benefit—benefits of that sort.

A maximum of two policies could be purchased. I purchased two policies. I must say that I relied heavily on the insurance department of the State of California that I felt would adequately protect me, and I am sure I am not alone in these feelings. I know that insurance companies must be licensed by a State before they can sell insurance in their State.

On receipt, I scanned the benefits section, and I read the large boldface type headings and did not read the light type, the small print. This was a mistake. Frankly, gentlemen, I am not sure that all of us and yourselves have read your insurance policies when it comes to your life insurance or your automobile insurance or your homeowners policy and so forth.

We, I feel, do rely heavily on our State to provide the protection that we should have against fraudulent, deceptive practices or against uneconomic policies that we may purchase.

Now, after I received a call from Mr. Phillips of this committee, which was just last week, I read the fine print in my file policy. I found that after the double-sized capital letter, heavy black-type heading: Hospital Benefits—Maximum Benefit $7,500—it sounds beautiful. In smaller type, this benefit is qualified—now get this—to $20 per day for the first 7 days and after that, $10 for each day for all expenses that I could incur for room, board, services, medicine, laboratory tests, and so forth. I would have to be hospitalized for 2 years and 13 days to reach the benefit, the maximum benefit.

I definitely feel it to be a false, misleading, and deceptive practice to offer $7,500 hospital benefit and qualify the benefit to the extent this policy does. When I bought the policy I thought it would pay up to $7,500 for any one hospital stay, which I think is a proper thing to believe.

In 1971, this benefit was revised. I got a flyer from the company which revised the benefits to a $25,000 maximum hospital benefit, but it qualified that, in the fine print, to $25 per day for the first 7 days and $15 a day for the next 83 days and so forth.

Mr. MARKS. Mr. Linn, when did you buy the policy?

Mr. LINN. I bought the policy in 1970.

The limit of all benefits on the policy is $25,000 under the revised 1971 benefit schedule. I would like to tell you what the policy says about the surgical benefits in it. It has in big, heavy, black type, capital letters, surgical benefits—maximum $1,500, but in smaller light type it qualifies this benefit to surgical procedures including postoperative care to $250 maximum per surgery. It then lists various common surgeries performed on cancer patients with a scale which ranges from $15 to $250, and out of 38 listed surgeries only four qualify for the maximum $250 payment.

I can tell you gentlemen it would be necessary for me to have at least seven major surgeries such as removal of my kidney, my bowel, my esophagus, my stomach, my lungs, a brain tumor to reach this amount of $1,500. It would be much more truthful to present the real coverage—a $250 maximum payment for a major surgical procedure. That is what the policy provides. I think this would be more honest than the way this benefit was presented to me. It was very deceptive to say that I was receiving $1,500 worth of surgical benefits protection. I though I was getting $1,500 protection for a single surgery.

I can go on with this, the $250 nursing benefit is limited to $12 a day maximum payment to a registered nurse only in a hospital. The $350 anesthesia benefit is limited in small print to a $35 maximum payment per operation to an anesthesiologist not employed by the hospital. This benefit should be presented as it is, a $35 anesthesia benefit for each surgery up to 10 surgeries.

The attending physician benefit, that is a beauty. The $250 maximum is in big print but limited in small print to $5 per day—only when you are in the hospital, not more than one visit per day.

Mr. PHILLIPS. Mr. Linn, in the interest of time, could you move into your claim experience?

Mr. LINN. Make it fast, sure.

In short, I feel that the company deliberately misrepresents the coverage by selling a prospective buyer on the maximum benefits provided and not advising the buyer of the qualifications involved.

I will go very rapidly through the experience I had with claims because I happen to have skin cancer. I had a skin cancer diagnosed in 1974. In November 1974, it was surgically removed. It was surgically removed by Dr. Fredrick Mohs, of the University Hospital, Madison, Wis., who wrote the book on skin cancer and has trained thousands of other doctors to use the procedures that he uses.

The doctor's report stated, "surgical excision of basal cell carcinoma." This claim was denied in a letter dated December 27, 1974, a copy of which I have, from American Family Life, because a basal cell carcinoma did not meet the policy definition of cancer. I have a copy of this letter wherein on January 4, 1975, I wrote and quoted my Webster dictionary definition of carcinoma which was almost identical to the policy's definition of cancer and had to point out the benefit schedule on the policy provided for $50 for removal of skin cancer so the policy must cover skin cancer, and my claim.

Now, on January 24, 1975, I received a reply from American Family Life Assurance Co., the gist being that I would have to supply a pathology report explicitly stating a malignancy. I had this sent and on February 25, 1975, finally received $114.40. I have had four additional skin cancer surgeries and I have had more or less difficulty with each claim. To quote one of my doctors, "We have had more trouble with American Family Life than with all other insurance companies combined," and another doctor wrote the company, "Ordinarily an operative report is adequate for all of our other insurance examiners as evidence of a cancer," after my claim, based on his medical report, was denied.

I have submitted paid bills covering my five claims totaling $1,534 and have been reimbursed approximately $625.

The company will not honor any claim without a pathologist's report, yet the policy specifically excludes and does not cover laboratory fees or a pathology cost. In sum, I believe the company makes every possible effort to deny paying claims. I think most people give up when their claim is initially turned down. I happen to be very tenacious.

Last year, the company doubled the premium yet the fixed benefit amounts were not increased 1 cent. This I just don't understand. I see up here that they are recovering a tremendous percentage of their premium against their payouts and they just doubled the premium on this policy.

No reconstruction surgery costs are provided for. Yet, I have two spots that I would love to have some surgery done, some reconstructive surgery done, as a result of removing skin cancer. They are pretty evident if you will notice my nose.

Thank you for listening to me. If you have any questions, I shall be glad to answer what I can.

Mr. PEPPER. I suggest that you go ahead, Mr. Phillips, and finish your inquiry and then we will have an opportunity to ask any questions.

Mr. PHILLIPS. Thank you very much, Mr. Linn. You say that each of these five claims, the company has not accepted the doctor's diagnosis of cancer, they require pathology reports.

Mr. LINN. Exactly.

Mr. PHILLIPS. Who pays for these reports?

Mr. Linn. I have to pay for pathologist's report that usually runs $30, yet the maximum payment for a skin cancer removal is $50.

Mr. Phillips. So you have to pay that.

Mr. Linn. Yes, sir.

Mr. Phillips. To even get your claim considered?

Mr. Linn. Yes, sir. They force you to provide them with a cost which they don't cover as far as being reimbursed. It is a catch-22.

Mr. Phillips. Does the company—each of these five claims, do they always accept the pathology report as authoritative?

Mr. Linn. Oh, that pathology report must—I have copies of letters from them wherein they refused the pathology report unless it specifically states a malignancy. They want it in their words.

Mr. Phillips. On how many occasions did that happen?

Mr. Linn. That was the very first one I had. After that whenever I submitted a report I asked the doctor to fill out the pathology report in accordance with his findings, but put it—have a pathologist do it which entailed additional cost because the doctor didn't need a pathologist.

Mr. Phillips. You had to pay for two pathology reports?

Mr. Linn. That is what it amounts to.

Mr. Phillips. Would you be so kind as to place all the material you cited in the record of hearing?

Mr. Linn. I should be glad to. I have quite a bit of it, some policies and all that sort of thing and my correspondence with them and their paid bills. Would you like that?

Mr. Phillips. All of that. Thank you very much.

[Material referring to the above is on file with the committee.]

[The prepared statement of Mr. Linn follows:]

Prepared Statement of Robert Linn

Mr. Chairman: My name is Robert Linn. I reside in Palo Alto, California. I am the national sales manager of an electronics firm in Mountain View, California. For twelve years prior to my present occupation, I was a vice-president of a carpet manufacturer with a sales volume over 100 million dollars a year. I consider myself an informed, sophisticated and intelligent businessman. However, I have been taken in by the deceptive sales tactics of American Family Life Assurance Company of Columbus, Georgia. I am certain that there are hundreds of people with more or less business experience than I have who have been and are also being fooled.

The very real danger to people who purchase cancer insurance policies from American Family Assurance Company lies in the fact that the possession of a cancer policy gives the owner a false sense of security and prevents the acquisition of other insurance that can provide real financial protection against the medical expenses of cancer. The American Family policy, in my opinion, based on my experience with the company is woefully inadequate in meeting the medical expenses of cancer with the benefits the policy provides.

The policy was presented to me as an all-inclusive protection against the medical costs of cancer with the major provisions of a $7,500 hospital benefit, $1,500 surgical benefit, $500 x-ray, $250 nursing, $350 anasthesia benefit, etc. A maximum of two policies could be purchased. I purchased two policies. On their receipt I scanned the benefits section, reading the large bold face type headings and did not read the light type small print. This was a mistake. Subsequently I have read the fine print and found:

1. After the double-sized capital letter, heavy black type heading: Hospital Benefits—Maximum Benefit $7,500, in smaller light type this benefit is qualified to $20 per day for the first 7 days and $10 for each day thereafter for all expenses incurred for room and board, all services, medicines, laboratory tests, etc., except if less than 30 days separates a successive period of confinement

the company will only pay $10 per day. I would have to be hospitalized for 743 days—two years and 13 days—to be paid the $7,500 hospital benefit. Yet the policy advertising emphasized $7,500 hospital expense coverage. I definitely feel it to be a false, misleading and deceptive practice to offer $7,500 hospital benefits and qualify the benefit to the extent the policy does. When I bought the policy I thought it would pay up to $7,500 for any one hospital stay.

In 1971 this benefit was revised to a $25,000 maximum hospital benefit but qualified to $25 per day for the first seven days and $15 per day for the next 83 days, etc. The limit of all benefits on the policy is $25,900 under the revised 1971 benefit schedule.

2. After the bold printed heavy black type capital letters Surgical Benefits—Maximum $1,500, in smaller light type it qualifies this benefit to surgical procedures including post-operative care to $250 maximum per surgery and lists various common surgeries performed on cancer patients with a scale ranging from $15 to $250. Out of 38 listed surgeries only four qualify for the $250 maximum payment. It would be necessary to have at least seven major surgeries such as removal of kidney, bowel, esophagus, stomach, complete brain tumor, to reach the $1,500 benefit. It would be much more truthful to present the real coverage—a $250 maximum payment for a major surgical procedure. This benefit is presented in a very deceptive way. I was under the impression that the policy would pay up to $1,500 for a single surgery.

3. The $250 nursing benefit is limited in small print to a $12 per day maximum payment to a registered nurse. The benefit should read $12 per day for twenty days to be truthful.

4. The $350 anesthesia benefit is limited in small print to a $35 maximum payment per operation to an anesthesiologist not employed by the hospital. This benefit should be presented as a $35 anesthesia benefit for each surgery up to 10 surgeries.

5. The attending physician benefit of $250 maximum is limited in small print to $5 per day—only while in a hospital. Not more than one visit per day is paid. An honest description of this benefit should be $5 per day, in hospital only, doctor's coverage up to a maximum of 50 days in the hospital.

In short, the company deliberately misrepresented the coverage by selling a prospective buyer on the maximum benefits provided and NOT advising the buyer of the qualifications involved.

CLAIMS EXPERIENCE

I had a skin cancer surgically removed on November 20, 1974. The doctor's report stated "surgical excision of basal cell carcinoma." This first claim was denied in a letter dated December 27, 1974, because a basal cell carcinoma did not meet the policy definition of cancer.

On January 4, 1975, I wrote and quoted my Webster dictionary definition of carcinoma which was almost identical to the policy's definition of cancer and had to point out the benefit schedule provided for $50 for removal of skin cancer so the policy must cover my claim.

On January 24, 1975, I received a reply, the gist being I would have to supply a pathology report explicitly stating a malignancy. I had this sent and on February 25, 1975 finally received $114.40.

I have had four additional skin cancer surgeries and have had more or less difficulty with each claim. To quote one of my doctors, "We have had more trouble with American Family Life than with all other insurance companies combined" and another doctor wrote the company, "Ordinarily an operative report is adequate for all of our other insurance examiners as evidence of a cancer," after my claim, based on his medical report, was denied.

I have submitted paid bills covering my five claims totaling $1,534 and have been reimbursed $675.

The company will not honor any claim without a pathologist's report, yet the policy does not cover laboratory fees.

In sum, I believe the company makes every possible effort to deny paying claims. I think most people give up when their claim is initially turned down.

Last year, the company doubled the premium—yet the fixed benefit amounts were not increased one cent.

Mr. PEPPER. Mr. Phillips, if you would not mind, it was suggested to me and I think it is a good suggestion, that we hear all the witnesses and then come back for questions.

Mr. PHILLIPS. Fine.

Mr. Pepper. Then we will get a clearer concept of what they all wish to say.

Mr. Phillips. The next witness is Mr. Schmidley.

STATEMENT OF STEVEN SCHMIDLEY, GREENSBORO, N.C.

Mr. Schmidley. Mr. Chairman, my name is Steven Schmidley, and I am an attorney from Greensboro, N.C. I am attorney for the estate of Harold Ray McGee. I represent Mr. McGee's estate in a claim against Mid-South Insurance Co. I am here today to relate to this committee the facts that underlie Mr. McGee's claim against that insurance company.

Mr. McGee was a 32-year-old man who obtained cancer insurance as part of a general medical policy from Mid-South Insurance Co., on April 1, 1978.

Thereafter on July 31, 1978, when Mr. McGee was in a dermatologist's office, Dr. Stuart Tafeen, in Greenboro, N.C., for another condition, he mentioned to Dr. Tafeen, "One of my friends noticed the mole that I have had on my back all my life, had it at least 20 years." He said, "Would you mind looking at it?"

The doctor looked at it and said, "I don't think there is anything wrong with it, but out of safety's sake, let me take a biopsy, some tissue from it and run some tests." The biopsy revealed that Mr. McGee had a stage II melanoma. This was some 4 months after he had taken out the policy with Mid-South.

Mr. McGee was hospitalized and the melanoma was surgically removed. Thereafter, he submitted a claim with Mid-South and they denied coverage. The first denial occurred in early January 1979. At the time of that denial, Mid-South had received the history and physical and discharge summaries from Moses Cone Hospital, the hospital where Mr. McGee had been hospitalized.

They had not received or made any contact with the doctor who biopsied the mole or the doctor who performed the surgery, nor had they contacted Mr. McGee either by telephone, by letter or in person. The basis of the denial was that they took the position that this illness was an illness contracted prior to the effective date of the policy. Subsequently, at the insistence of the agent who had procured the medical insurance for Mr. McGee's company, Mid-South undertook to review their denial.

They received a letter from Dr. Tafeen which was the first communication they had had with Dr. Tafeen. In June 1979, Mr. Zinn wrote a letter in which the following paragraph was included:

> Mr. McGee had noted a mole between the shoulder blades for at least the last 20 years. Whether this lesion was a melanoma at the time or turned melanoma a few months before he sought consultation does not alter the situation.

During the course of the deposition taken of Mr. Zinn I asked him what the phrase "at the time" meant. He said it meant at the time he took out the policy. So, I asked Mr. Zinn again, "What is the rationale behind denying Mr. McGee's claim for benefits?" The response I got is that Mr. McGee had a mole on his back when he took out the policy. He knew he had a mole when he took out the policy and regardless of when the melanoma developed, whether it was before the policy or after the policy, there was a preexisting condition.

I asked Mr. Zinn during a telephone conversation in my office, my first conversation, I said, "Mr. Zinn, I have a heart. I know I have a heart when I take out your policy. Six months later I have a heart attack. Is that a preexisting condition?"

Mr. Zinn was quiet for a moment. He says, "Well, under the terms of the policy it might be." [Laughter.]

In July 1979, Harold McGee, they discovered he had a brain tumor. He was hospitalized at Wesley Long Hospital in Greensboro, N.C. He couldn't go back to Moses Cone because he still had an outstanding bill that had never been paid.

He was transferred to Duke University Hospital in Durham, N.C., and underwent brain surgery. He returned home a very, very ill man, unable to work. He ran a small company himself and when he couldn't work the company made no money.

In September, he was again hospitalized in Wesley Long Hospital, a body scan indicated he had a massive melanoma development throughout the abdomen, kidney, and liver area. He was again transferred to Duke University Hospital—his condition was inoperable. He was returned home and placed on chemotherapy treatments.

In early October, at the age of 32, while he was in Alabama, visiting his brother, he lapsed into a coma and died. His estate is now facing medical bills of in excess of $30,000 medical and hospital bills, none of which have been paid.

During the course of investigating this claim and pursuing the litigation, I have taken the deposition of Mr. Zinn and asked him what the legal meaning is of the phrase, "a condition which existed or an illness which was contracted prior to the effective date of the policy meant."

He said, "A condition which had its medical inception."

I said, "Even if there had been absolutely no outward manifestation to the insured that anything was wrong?" He said, "That is my definition of the phrase." It is without question and it is not disputed, to my knowledge, by Mid-South that there had been anything which would indicate to Mr. McGee anything other than the fact that he had a mole on his back.

The doctors who treated Mr. McGee are of the unanimous opinion that the subsequent melanoma developments which ended in his death were directly related to the initial melanoma which was on his back.

I would like to thank the members of the committee, and you, Mr. Chairman, for the opportunity to appear before these committees and to relate to you the story of Mr. Harold McGee.

[The prepared statement of Mr. Schmidley follows:]

PREPARED STATEMENT OF STEVEN S. SCHMIDLEY

My name is Steven S. Schmidley, and I am an attorney from Greensboro, N.C., and I represent the estate of Harold Ray McGee in an action which has been filed against his medical insurance carrier. I have been requested to appear before this committee to relate to you the facts surrounding Mr. McGee's involvement with cancer and the problems he had with his medical insurance in paying his doctor and hospital bills.

The factual background of this matter is as follows:

Mr. Harold R. McGee, a 32-year-old white male, obtained a group health insurance policy for the employees of his company, including himself, from Mid-South Insurance Co. on April 1, 1978. This group insurance policy was policy number BPPA 2550, certificate No. 91455, and was issued by Mid-South Insurance Company.

Thereafter on July 31, 1978, Mr. McGee while consulting Dr. Stuart Tafeen, a Greensboro, N.C., dermatologist on another matter, requested Dr. Tafeen to examine a mole which had been on his back for at least the last 20 years. According to Dr. Tafeen's records, a friend had seen the mole and stated to Mr. McGee that he should have it examined.

During the examination by Dr. Tafeen, a biopsy was performed on the mole as a safety precaution. The biopsy results showed that the area under the mole contained a stage II melanoma. The mole and the surrounding area were surgically removed on August 31, 1978 and Mr. McGee was confined in Moses H. Cone Memorial Hospital in Greensboro, N.C., from August 30, 1978, until September 4, 1978.

At the time of his examination by Dr. Tafeen and when Mr. McGee was later admitted to Moses H. Cone Memorial Hospital, Mr. McGee denied that the mole had changed in size or color, was painful or itchy. I have determined by speaking with Mrs. McGee that no noticeable change had occurred in the area of the mole on his back, and the mole had not bled on Mr. McGee's clothing or bed sheets.

After Mr. McGee's hospitalization he filed a claim with Mid-South Insurance Co. under the group medical insurance policy, and by a letter dated January 6, 1979, Mid-South denied coverage for the melanoma. The basis of the denial was section 3(a) of the policy which provides an exclusion for any illness contracted prior to the effective date of the policy during the first policy year and maximum benefits of $500 during the second policy year. At the time of the denial of the claim, Mr. Sanford Zinn, senior claims examiner of Mid-South Insurance Company, had received the history and physical and discharge summary from Moses H. Cone Memorial Hospital. Mr. Zinn did not contact Dr. Stuart Tafeen, the physician who had biopsied the mole or Dr. Farley, the physician who performed the surgery, and did not contact Mr. McGee by phone, letter or in person prior to initially denying Mr. McGee's claim.

Subsequently, at the insistence of the agent who had procured the medical insurance for Mr. McGee's company, Mid-South reviewed its denial of Mr. McGee's claim. This was done on June 21, 1979, and the letter requesting the review included a statement prepared by Dr. Tafeen which was dated April 26, 1979. This was the first communication between Mid-South and Dr. Tafeen. On June 25, 1979, Mr. Zinn of Mid-South Insurance Company wrote a letter to Lynn Lambert, the person who procured the medical insurance policy, denying the claim for a second time. In this letter, Mr. Zinn stated: "Mr. McGee had noted a lesion (mole) between the shoulder blades for at least the last 20 years. Whether this lesion was a melanoma at the time or turned melanoma a few months before he sought consultation does not alter the situation."

During Mr. Zinn's deposition which was taken during the course of discovery he stated that the phrase "at the time" meant at the time the policy was issued. The reasoning for the denial is simply stated that Mr. McGee had a mole and knew it, and thus regardless of when the melanoma developed the condition was a condition which existed when the policy became effective.

In late June 1979, Mr. McGee was hospitalized at Wesley Long Hospital and a brain tumor was discovered. This tumor was determined to be a melanoma. Mr. McGee was transferred to Duke University Hospital in Durham, N.C., and on July 3, 1979, Mr. McGee underwent brain surgery. Of course, Mid-South refused and continues to refuse to pay these hospital and doctor bills. Subsequently, in early September 1979, Mr. McGee was hospitalized again in Wesley Long Hospital and a "body scan" indicated massive melanoma in the abdomen, kidney, and liver area. Mr. McGee was again transferred to Duke University hospital, but his condition was inoperable. Mr. McGee returned home in mid-September 1979, and in early October, Mr. McGee, while on a trip to Alabama to visit his brother, lapsed into a coma and died. The doctors who had treated Mr. McGee are of the unanimous opinion that the subsequent melanoma involvements are directly related to and connected with the initial stage II melanoma which was discovered on Mr. McGee's back in July, 1978.

It should be noted that on May 10, 1978, Occidental Life Insurance issued Mr. McGee a $150,000 life insurance policy. As part of this application process Mr. McGee was given a medical examination in Greensboro, N. C., on March 15, 1979. After Mr. McGee's death Occidental Life conducted a complete review of his illness, which included contact with each doctor who treated Mr. McGee, and after this investigation Occidental Life paid the insurance monies to Mr. McGee's widow.

A civil action was filed in the Superior Court of Guilford County, N.C., on July 12, 1979, seeking recovery from Mid-South Insurance Company for the hospital and doctor bills incurred by Mr. McGee and punitive damages for the bad faith refusal of Mid-South to pay the claim. During the course of this litigation, the deposition of Mr. Sanford Zinn, the senior claims examiner of Mid-South Insurance Company was taken. During the course of that deposition Mr. Zinn testified as follows:

Question. So wouldn't it be a fair statement that the rational behind the denial of the claim for Mr. McGee as of January 6th, 1979, is something to the effect that "Mr. McGee, you had a mole and you had a mole when this policy was effected and, therefore, regardless of when that mole became a melanoma, you did not receive any coverage under this policy," is that correct, sir?

Answer. He did know he had this lesion or mole, yes.

Question. He had a mole, and he knew it?

Answer. That is right.

Question. And regardless of when it developed into a melanoma, he has no coverage under the policy, isn't that the rationale behind your letter of January 6, 1979?

Answer. I do not know how you are using the term "rationale". It wasn't a rational decision; it was based on the fact that these records show he had this particular lesion for twenty years and he knew it and based on the policy provisions, it was denied on that basis.

Question. What was the illness that Mr. McGee had, what was the illness, melanoma?

Answer. Right.

Question. There is no contention by you, sir, or by Mid-South, that he had that mole removed as part of cosmetic surgery?

Answer. Cosmetic wasn't mentioned.

Question. You had no facts as of January 6, in your possession, to know when the melanoma developed, did you?

Answer. No.

Question. And you found that to be an irrelevant consideration because he had this mole and he knew he had the mole, at that time?

Answer. It was mainly that he did have the mole, or lesion.

Question. * * * Just one other question concerning the January 6, 1979 letter. Other than his knowledge of the mole or the lesion on his back, you had no facts in your possession or no knowledge of any other outward manifestations of anything being back there other than just a mole, did you?

Answer. I only had what information was in the records.

Question. Is there any information in the records there showing any outward manifestation of, that to Mr. McGee's knowledge, other than the fact he had the mole back there?

Answer. To the best of my knowledge, no.

This deposition testimony related to the initial denial of Mr. McGee's claim which occurred on January 6, 1979. Further, during Mr. Zinn's deposition, Mr. Zinn stated that he did not know the legal meaning of the phrase preexisting condition or a condition contracted prior to the effective date of the policy, that his definition of the term relates solely to the medical inception of the disease. Mr. Zinn believes that "medical inception" is the key even if there has been no outward manifestation of the condition to the insured.

During his deposition Mr. Zinn further testfied that:

Question. Now, Mr. Zinn, did you have an opportunity at some later time to receive further information concerning this claim that Mr. McGee submitted?

Answer. After I had sent the January 6 letter, then a letter was received, I believe by Doctor Tafeen.

Question. Let me hand you two paper writings, one marked Plaintiff Exhibit 2 and one marked Plaintiff Exhibit 3, and ask you to look at those, please.

Answer. [Witness apparently reading documents.]

Question. Have you had an opportunity to review those documents?

Answer. Yes.

Question. After reviewing those two documents, would it be correct for me to state that you received Doctor Tafeen's letter which is dated April 26, 1979, as an enclosure of June 20, 1979 letter to you from Lynn Lambert, which is dated June 20, 1979 and marked as Plaintiff Exhibit 2?

Answer. Yes.

Question. Do you have those correspondences in your file?

Answer. Yes.

Question. Would you please find those and see the date of receipt on those, please?

Answer. Doctor Tafeen's letter was received June 21; the letter from Lynn Lambert was received June 21.

Question. Okay, upon receipt of Doctor Tafeen's letter, the document marked Plaintiff Exhibit Number 3, what, if anything did you do?

Answer. Well, then I went to look into the claim further, so on July 5th, I believe it was, I wrote Doctor Tafeen.

Question. Mr. Zinn, isn't it true, sir, that before July 5, when you wrote Doctor Tafeen, you denied this claim one more time?

Answer. Yes.

Question. So, after you received Doctor Tafeen's letter, you did no further investigation at that time, did you, sir?

Answer. No.

Question. And it was only after a telephone call from me that you decided you would look into the claim further, sometime before July 5, 1979, isn't that correct?

Answer. That is probably correct.

Question. Okay, so you received the April 26, 1979 dated letter on June 21. What, if anything, did you do, sir?

Answer. After I received that letter, I again denied the claim.

Question. On what basis did you deny the claim at that time?

Answer. On the basis again, on the fact that the insured had had this mole or lesion on his back for twenty years or whatever.

Question. I am going to ask you to review Doctor Tafeen's letter, which is marked Plaintiff Exhibit Number 3, and I am going to ask you this question—

Answer. Which letter is that?

Question. Doctor Tafeen's letter, Plaintiff Exhibit Number 3, this one right here, sir.

Answer. All right.

Question. Mr. Zinn, isn't it true that that letter, which you received on June 21, is the first record or any report of any kind that you ever had in your possession which in any way indicated when the melanoma may have developed?

Answer. This is the first inkling of when it may have developed, when he indicated that it may have undergone clinical changes a few months before he sought consultation.

Question. There is absolutely nothing in that letter which in any way indicates that prior to April 1st, 1978, that Mr. McGee had any idea of any symptoms that anything was wrong with the mole that he had on his back and that he had had for some twenty years?

Answer. Except which had been pointed out by a friend.

Question. And you had no idea when the date of that was, did you?

Answer. No.

Question. And it would not have made any difference to your determination when the date of that was, would it?

Answer. No.

Question. So, if that friend would have seen him on July 30th, before he went to see Doctor Tafeen on July 31, and say "You ought to have the mole checked into," even though that was after the effective date of his policy, it would not have made a bit of difference in your determination?

Answer. My determination was made mainly on the fact that he had this for a long period of time.

Question. He had had this what?

Answer. The lesion.

Question. The lesion or the mole?

Answer. Right.

I believe that this testimony clearly reflects the rationale, or total lack thereof, behind the denial of Mr. McGee's claim by Mid-South Insurance Company. Mr. McGee had a mole and knew he had a mole when he was issued the policy, and thus, he had a preexisting condition regardless of when the mole developed into a melanoma. The same rationale could easily be applied in the following way: The insured had a heart attack and knew he had a heart when the policy was issued and thus his heart attack was a preexisting condition when it occurred 6 months later even though the insured had no knowledge of any manifestation that he had any kind of trouble.

Mr. Phillips. Thank you very much, Mr. Schmidley.

Our next witnesses will be testifying jointly, Mr. H. W. Jack Sturgeon, and Chief Earl Meiers.

STATEMENT OF W. W. JACK STURGEON, WEST HELENA, ARK., ACCOMPANIED BY EARL MEIERS

Mr. Sturgeon. My name is W. W. Sturgeon of West Helena, Ark. I am a retired foreman from the Chicago Mill & Lumber Co., in West Helena, Ark. I am a volunteer member of the West Helena Fire Department.

Chief Meiers will read this affidavit which I have.

Mr. Meiers. Mr. Phillips and Mr. Chairman, I would like to read Mr. Sturgeon's affidavit.

> I am a retired foreman from the Chicago Mill & Lumber Company in West Helena, Ark. I am a volunteer member of the West Helena Fire Department. I have been a member of the auxiliary Fire Department for West Helena for approximately 20 years.
>
> We don't get much pay for our firefighting services because our town of about 12,000 people over in the Delta along the Mississippi River Valley can't afford all full-time firemen. The volunteer fire department is a civil as well as a social club. We meet two times a month and go to most of the fires to help the few regular full-time firemen protect the homes in our town.
>
> In 1968, I took out, along with other firemen, a cancer insurance policy with American Family Life Assurance Company of Columbus, Georgia. The agents when they appeared before us at the City Hall in West Helena to get us to buy the policies and told us in 1969 that if we had cancer the benefits would be paid even if we were in the Veterans Hospital and regardless of any other benefits we might have.
>
> I kept my policy up. In 1975, I began having trouble with my throat and was hospitalized by my family doctors in our local hospital. I was ultimately hospitalized and operated on for cancer in the Veterans Hospital in Memphis. I was hospitalized and operated on for cancer at the VA hospital in Memphis. Our local hospital bill was around $979.55. I was hospitalized for seven days. That bill has never been paid. I was hospitalized at the VA hospital in Memphis on three different occasions, 28 days, 19 days and 5 days. I have never been paid benefits for this period of time.
>
> I paid premiums from 1968, on a group policy up through the time I retired which was in September of 1975, and after retiring I began to pay the premiums on a non-group basis and paid the premiums up until 1976. My Helena Hospital bill has never been paid. My benefits due to me while I was hospitalized in the Veterans Administration Hospital and in our local county hospital have never been paid.
>
> I understand, Mr. Phillips, that you and your committee are investigating abuses in the insurance industry. I definitely feel that the American Life Insurance Company of Columbus, Georgia, has taken advantage of me and has done me wrong. I work hard for my money and I have paid these premiums and they have never paid the benefits. I urge that you and the Federal Government stop these abuses by the insurance industry. It is not fair for this company to take my money and not pay me the benefits. This has kept me torn up for many years. This is making my health problem greater.

Mr. Phillips, that is all of Mr. Sturgeon's statement.

[A copy of Mr. Sturgeon's affidavit can be found in the appendix.]

Mr. Phillips. Chief Meiers, I understand that you witnessed the sales pitch in 1969.

Mr. Meiers. That is correct.

Mr. Phillips. Of the insurance agent and that you have your own statement, sir.

Mr. Meiers. Yes, I have my own statement, if you will. I would like to read it.

Mr. Phillips. Thank you.

Mr. Meiers. I was present in 1968 when the insurance agent first solicited me and the other firefighters for the insurance.

West Helena is indebted to citizens such as W. W. Sturgeon. Our town cannot afford a full-time, fully staffed fire department.

We have approximately 20 men, including Mr. Sturgeon, as volunteer firefighters to protect the homes in our town from fires. They respond to the fire alarms along with us full-time firefighters.

It hurts me to see how Mr. Sturgeon has been treated by this cancer insurance company. I heard the agents tell him in 1968 that American Family will pay hospital benefits directly to him, regardless if the patient were in a Government hospital or any other cancer insurance.

On April 15, 1975, I took out the same type of policy with American Life.

Mr. Phillips. The same company, American Family Life?

Mr. Meiers. Same company.

But the policy has been changed. This is on Mr. Sturgeon's. I kind of jumped ahead of myself. This is on Mr. Sturgeon's, on April 15, 1975, I believe.

This policy has been changed to specify exclusive benefits when the patient went to a VA hospital. This is in my policy.

Mr. Phillips. Your group?

Mr. Meiers. My group policy.

Jack's policy did not spell out or indicate that a $50 a day benefit will be paid to him when the patient was confined to any kind of hospital. What American Family has done is changed Jack Sturgeon's policy without his permission. That is illegal.

Both his policy reads, "No changes in this policy should be valid until approved by the executive office of the insurance company unless approved and signed by the insurer or endorsed hereon attached hereto."

Mr. Sturgeon never gave such an endorsement.

Many of the other members of our fire department are disturbed over how our friend and fellow firefighter, Jack Sturgeon has been treated by the American Family Life Assurance Co. of Columbus, Ga.

I have with me two other affidavits of two other firefighters who have personel knowledge of the insurance company's soliciting in the insurance business. They support Mr. Sturgeon's statement that the agents sold the policy on the basis that a hospital or confinement benefit will be paid if the insurer stays in a Government hospital.

Mr. Chairman, with your permission, I would like to file these affidavits, at this time, along with my affidavit and Mr. Sturgeon's, personally, in behalf of the members of the West Helena Fire Department and appreciate you and your subcommittee's investigating. We hope you will be able to stop this abuse by insurance companies.

Thank you, sir.

[Additional affidavits of Mr. Meiers, Mr. Sanford, and Mr. Deaton can be found in the appendix.]

Mr. Pepper. Without objection, so ordered.

Mr. Phillips. Thank you very much.

Our next witness is Dr. Dan Kenshalo, Florida State University.

STATEMENT OF DR. DAN KENSHALO, FLORIDA STATE UNIVERSITY

Dr. KENSHALO. I am Dan Kenshalo. I am a professor of psychology at Florida State University with a specialty in physiological psychology. I have been there for the past 30 years. As a matter of fact, that is my entire academic life.

My mother-in-law, Mrs. Eunice Gordon, was treated for lung cancer during the period from February 9, 1976, through April 1, 1976. I became involved in it when her husband, Mack Gordon, asked me to look over her insurance policies and to see if the settlements proposed by the companies were in conformity with the terms of the policy.

She had incurred, during this interval, hospital bills for rooms and services in a total of approximately $8,800. American Family Life, the cancer policy issuer, proposed to pay some $2,750. That is approximately 20 percent of the total bills incurred. This left the Gordons with about $6,000 to somehow come up with in order to pay the balance of the bill. Now the Gordon household consists of Mr. and Mrs. Gordon and Mrs. Gordon's mother and they exist on an income of slightly over $600 a month.

You can imagine what kind of a burden that places on an already stretched budget to come up with another $6,000 in order to meet their obligations, but come up with it they will because the Gordons are reputable people, they recognize their debts and they make every effort to pay them.

She had two policies with American Family Life. One was a general hospitalization policy that covered only room to the extent of $28.57 a day, exclusive of the first 4 days of hospitalization. The other was a cancer policy, which provided for certain other services.

Of course, there was not much to review, and with the general policy it was rather straightforward. But in reviewing the cancer policy, I found two types of discrepancies between the claims department interpretation of the responsibilities of the company and my interpretation of the responsibilities of the company. The first type of discrepancy was an out and out error. They failed to count properly the number of days that Mrs. Gordon was hospitalized. For example, the second type of error I would characterize as "sharpshooting." Drug allowances, for example, were figured at 10 percent of the domiciliary rate, whereas the policy clearly stipulated that drug expenses should be calculated at 20 percent of the domiciliary rate. That statement was in the fine print of the policy.

A second type of sharpshooting—what I would call sharpshooting at any rate—was the denial of 9 days of hospitalization, plus services, for Mrs. Gordon when she was readmitted to the hospital some 9 days after being discharged following surgery for removal of a lung lobe.

It does not seem reasonable to me, and her physicians concur, that if she had not had the surgery, she would have developed pleurisy. Because it was diagnosed as pleurisy, their diagnosis was the basis of denial of support. Her physicians, as well as I, maintain that the pleurisy was as a direct result of her having had the surgery, and that she would not have developed pleurisy had she not had the surgery. As a result of this review, we filed an additional claim with the company for some $1,000 additional in expense.

After many telephone calls to the claims department, I finally got on the phone and called Mr. John Amos, president of the company, and said, in effect, "Let's get on with it, either make up your mind which you are going or I am going to the Georgia Insurance Commissioner." That seemed to stimulate a remembrance in his mind because very shortly thereafter they allowed our $1,000 in claims. This still left the Gordons with some $5,000 to come up with in order to meet their obligation.

In my estimation, the three most glaring deficiencies of the policy, when I went through the review process, were first, inadequacy in allowances. While her two policies together barely covered the domiciliary charges, certainly the cancer policy covered no more than 50 percent of them. In terms of surgical procedure, there is no provision for operating room expenses. There is no provision for diagnostic X-ray. There is no provision for or very limited provision for expenses in drugs. There is a rather generous provision for X-ray therapy.

Furthermore, along this same vein, there is a second kind of inadequacy.

Mr. **Phillips.** Excuse me, Dr. Kenshalo, could you wrap up the statement?

Dr. **Kenshalo.** Yes.

Mr. **Phillips.** I understand you have an airplane to catch.

Dr. **Kenshalo.** I sure do.

The second type of inadequacy is, of course, the type of services that may be presented. Chemotherapy, for example, is never mentioned in the policy. Also not covered but a very large part of her expense was respiration therapy, a therapy necessary in conditions of lung cancer.

I consider that the largest step forward that we could make would be to require insurance companies to express their policies in clear, simple English without dependent clauses stretching from yea to yea. If the people who buy these policies had at least an opportunity to understand what they are buying, I think it would be a large step forward for them to be able to compare the claims of the agent that sells them to them with what the policy actually states. Thank you.

Mr. **Phillips.** Mr. Chairman, since Dr. Kenshalo has a plane to catch, I wonder if members of the committee have any questions of him?

Mr. **Pepper.** Yes; I would like to ask each member of the panel one question. You can be sort of preparing your answer, if you would.

First, what was the name of the company with which you dealt?

Dr. **Kenshalo.** American Family Life.

Mr. **Pepper.** Do you know how much premium the covered person paid in to that company?

Dr. **Kenshalo.** Yes, sir. She paid in $60 a year for a period beginning November 15, 1971.

Mr. **Pepper.** Up to what date?

Dr. **Kenshalo.** I don't know whether he still maintains that policy or not. I advised him to drop it.

Mr. **Pepper.** Do you know what was the total amount of damage or loss sustained by the covered individual?

Dr. **Kenshalo.** The total loss was in excess of $8,800.

Mr. **Pepper.** How much?

Dr. **Kenshalo.** Some $8,800.

Mr. **Pepper.** How much was the covered individual paid by the company?

Dr. KENSHALO. Eventually, after we went back at them, $2,700, which represents about 31 percent.

Mr. PEPPER. Thank you very much, Dr. Kenshalo.

Thank you for coming to be with us today.

Dr. KENSHALO. Thank you for asking me.

Mr. PHILLIPS. Thank you, Dr. Kenshalo.

Our next witness is Mrs. Sobiesiak, of Cherryville, Pa.

STATEMENT OF MRS. MARIAN SOBIESIAK, CHERRYVILLE, PA.

Mrs. SOBIESIAK. Thank you, Mr. Chairman, gentlemen, and ladies.

Early last year I was contemplating getting more health insurance coverage. Everyone in my family, my mother, father, aunts, and uncles had succumbed to cancer. I thought I would help my husband meet some of the expenses if I should come down with it.

We decided on Union Fidelity. The premium was cheap, just $59 and some cents a year. Well, I filed the application, sent a full year's premium and was informed our policy was in force as of April 22, 1979. On May 20, my husband attended a banquet given by his bowling team. He imbibed a little too much, as all of you would, at a banquet. At one point he went to the bathroom and passed two small blood clots in his urine. He had no pain.

When he came home, he didn't say anything to me. The next day he mentioned it to me. He had no more bleeding, so, since we had an appointment with the doctor for the 22d, we didn't call the doctor. I went with him to the doctor, just to make sure he would tell the doctor about this.

Dr. Eslinger examined him, took his blood pressure and said his abdomen was distended and he thought his liver felt a bit enlarged and his blood pressure was elevated. He sent him home with medication, told him to rest and he would try to get us an appointment with someone who might help us. On Wednesday, he told us to go to the Osteopathic Hospital in Allentown and meet with the LIMA group.

We came to the hospital and the doctor examined my husband. Now he also confirmed that he felt the liver was the cause of the trouble and the blood pressure was very elevated. He was admitted, and, after several attempts at abdominal taps, with no success, laboratory tests, blood tests, urine tests were done. Everything was negative. X-rays were taken. Upper GI series, and nothing showed up. They decided maybe it was just gas in his intestines.

Finally, on May 30, they scheduled a cystoscopic. A biopsy was done on the bladder. Dr. Sherman sent the specimen to a naval hospital here in Washington. On June 1, we were given the horrible and most unexpected diagnosis, cancer of the bladder, a type very rare. Five or six are reported in the medical journals.

Well, after a long convalescence, my husband was operated on June 4. I have to go back to this. He was operated on June 4, because his urine—he wasn't producing any urine. The doctor thought that perhaps something was obstructed. He did a urostomy and now he has two tubes in his kidneys. He improved somewhat, but he had a long convalesence, up until July 5. Dr. Sherman told us not to expect any miracles. Well, on his discharge we applied to the Union Fidelity to pay us for his hospitalization. We figured they owed us about $1,800 in benefits just for the room alone, but——

Mr. Phillips. What is the hospital confinement benefit—a sort of disability income?

Mrs. Sobiesiak. They were supposed to give us $60 a day for the first 7 days, and $40 for the rest of the time. Finally, in late August or September we were told they would not pay us because the disease manifested itself before the 30-day waiting grace period, that we knew he had cancer and had taken the policy because of that.

I tell you, ladies and gentlemen, that it is not so. I got the policy for me, not for my husband. My husband did have some abdominal enlargement prior to his illness. The family doctor told us to cut down on his food. We tried but my husband likes to eat. He always drank a lot of liquids—between 3 quarts and 1 gallon a day, therefore, naturally, he had frequency of urination. The doctor will tell you too that frequency is not uncommon in older men; one of the reasons may be an enlarged prostate gland.

The company was approached again for the second admission where my husband had a colostomy. We were turned down again. So, gentlemen, according to the insurance company, if any of us, and it could be possible, are walking around with cancer without knowledge and take out a policy and come down with it, God forbid, on the 30th day, they are not required to honor the same. If tests don't show it, if doctors can't confirm it, how does the insurance company justify?

[The prepared statement of Mrs. Marian Sobiesiak follows:]

Prepared Statement of Mrs. Marian Sobiesiak

When I bought my cancer policy on April 22, 1979, I bought it to protect my husband from any excessive cost of treatment I might bring him if I ever came down with cancer. Both my parents, and several of my uncles have died of it. My husband's getting cancer was the furthest thing on my mind at the time. I had him pegged for emphysema. Things happened differently. He became "ill" (the first symptom of something wrong) was on May 22, 1978, when after a banquet he passed a blood clot in his urine. We went to see our doctor, Dr. Eslinger, who checked him out, because of the bleeding and abdominal distention. His blood pressure was elevated at the time, too. The doctor said to go home, rest, and he gave my husband some pills to take, and told us he would make an appointment with a specialist to check him out. Nothing was said about cancer.

Dr. Eslinger called the next day and told us to go to Allentown Osteopathic Hospital and have the LIMA group doctors see him. On May 24 we went down there. Dr. Starr saw my husband, checked him out and said he thought he should be admitted because of his elevated blood pressure and severe abdominal distention. When asked why the distention, he said it sounded as if there was fluid there and they would have to do a tap. He was admitted. They tried to tap his abdomen, but could get nothing. Fluids were restricted, blood tests were done. X-rays were done with no results. Finally they called Dr. Robert Sherman, a urologist, who did a cystoscopic, then ordered more X-rays, and a repeat cystoscopic taking a biopsy of the bladder, on May 30.

On June 1, Dr. Sherman told us the shocking news that my husband had a cancer which was inoperable. Such shocking news I wouldn't wish on my worst enemy. We were stunned! Dr. Sherman said he'd get some other doctors to look at the tests and see what they had to say. They all agreed on the diagnosis and concurred the futility of further treatment. On June 2, my husband began to get lethargic and confused. The next day he was worse, barely recognizing anyone.

Dr. Sherman scheduled him for surgery on Monday June 4, because he said his urine was not coming out and he'd have to do a nephrostom on him to relieve him of toxemia. The doctor operated on June 4, and within a few days my husband was alert again. The right kidney was barely draining, but the left made up for the deficit. The tumor was not removed. During his convalescence he had a few setbacks, but finally with God's help and the doctors and nurses who were just super, he was finally discharged on July 5. While he was in the hospital we filed the form for the cancer policy, with Union Fidelity Life Insurance Co. of Pennsylvania. We figured they owed us about $1,800 in hospital confinement benefits. We kept hearing from the company that they were processing our claim. Finally they wrote and told us they would not pay because my husband must have contracted the cancer prior to my getting the insurance. If he did we were not, I repeat, we were not aware of the fact. Our family doctor was just as shocked as we were when he heard the news. So—does the company just ignore our plight because the cancer was present without our knowing it? All the doctors told us that with this type of cancer, when symptoms appear, it's too late. Can someone please tell me, how is a person to know if he has cancer or not. Evidently it does not show up in tests all the time. To my way of seeing things, the cancer manifested itself the day we found he had it. We all may be walking around with a malignancy, I hope not! But how can the insurance company sell you insurance promising help and then go back on its word. Thank you.

Mr. Phillips. Thank you very much.

Mr. Pepper. I understand that Mr. Denenberg, who was to be a part of the panel of regulators here, a former insurance commissioner of Pennsylvania, has to leave.

If we may, we will ask Mr. Denenberg to come up to the witness table and give his statement and then we will come back to the questioning of the other members of the panel.

STATEMENT OF HERBERT DENENBERG, FORMER INSURANCE COMMISSIONER OF PENNSYLVANIA

Mr. Denenberg. First, I would like to thank the committee for the invitation to be here. Second, I would like to submit my written statement for presentation, if I may.

Mr. Pepper. Without objection your statement will appear at the conclusion of your oral testimony.

Mr. Denenberg. Thank you.

Cancer insurance has two main values. First, it produces handsome profits for those willing to sell it.

Mr. Pepper. Will you state for the record, what association you have had with this general subject of insurance regulation?

Mr. Denenberg. Actually, that is in my statement. I am a former Pennsylvania Insurance Commissioner, a former professor of insurance at the Wharton School, a former insurance consultant for the Small Business Administration, U.S. Department of Labor, Federal Trade Commission, the Small Business Administrations of the States of Wisconsin, Nevada, and the District of Columbia.

I have authored many books on the subject of insurance regulation. I also tried to outlaw cancer insurance while insurance commissioner of Pennsylvania, unsuccessfully.

Mr. Pepper. Thank you.

Mr. Denenberg. Cancer insurance has two main values. First, it produces handsome profits for those willing to sell it. Second, cancer insurance is a perfect, shining, flawless example of everything good medical expense insurance should not be. Considered in the abstract, from the point of view of sound and accepted insurance principles, cancer insurance would be adjudged a lousy product. Considered as it performs in practice in the marketplace, cancer insurance is worse than a lousy product.

I would summarize by saying cancer insurance is an expensive form of junk, gimmick, Mickey Mouse, limited coverage that gives little value for its premium; that is inherently inefficient and uneconomical; that often contains tricky, deceptive and unfair provisions, loopholes and fine print: that has often been sold not by fact but by appeals to fear, superstition, and the irrational; that has been frequently misrepresented in advertisements and sales presentations, and that is often sold to those that are least likely to need its limited protection.

Here is how cancer insurance violates every accepted principle of buying sound medical expense insurance. The first rule of buying sound medical expense insurance is to get comprehensive protection. You need protection against medical expenses whether arising from disease or injury, from a common disease or a rare one. Cancer insurance makes about as much sense as leprosy insurance or smallpox insurance or chickenpox insurance. If you bought policies, disease by disease, you would soon have a bushel basket full of policies and a thimbleful of money.

There are a couple of problems with buying medical expense insurance on a disease-by-disease basis. First, you are engaging in gambling or wagering, not insuring. You are betting that you will get one disease rather than another, a bet that you will almost surely lose and end up with uninsured medical expenses.

Why is cancer insurance a wager? If you buy cancer insurance, in some cases you may be getting protection for about 1 percent of your potential medical bills, maybe a little more or maybe a little less. I am talking about all medical bills for all disease and all injury. You are still going to be unprotected, even with fairly good cancer policy, for 99 percent or so of potential exposure.

According to a study from the National Center for Health Statistics, cancer accounts for about 4.3 percent of all medical expenses. Now the major seller of cancer insurance claims to pay only 35 to 40 percent of medical expenses for cancer treatment of their policyholders.

Taking that at face value, taking that heroic assumption, even according to the most favorable assumptions of this cancer insurer, it is paying for only 1.6 percent of the total medical cost, considering both the exposure to cancer and all other diseases and injuries. This is based on the most favorable assumption of what cancer insurance pays for. One company, according to studies, pays only 11 percent of all cancer bills; 11 percent of cancer bills as a percentage of all medical expenses comes down to less than one-half of 1 percent of all medical expenses.

So, from an overall point of view, cancer coverage may be paying about 1 percent or less of your overall potential medical bills. You are getting 1 percent coverage for a premium of $35 to $210, which means going that route for full coverage of all disease and injury, you would have to have 100 different policies to cover 100 percent of all medical expenses, and it would cost you $3,500 to $21,000 a year.

Cancer insurers say if you get cancer, you are in good shape with one of their policies. But, by leaving yourself uninsured for about 99 percent of potential expenses, you are almost sure to lose your gamble.

Buying insurance on a policy-by-policy basis has another defect. It means you are paying each insurance company its fixed costs and other expenses, and getting the reverse of a quantity discount. You are getting a quantity markup. You are also increasing the chances that a group of policies won't fit together properly, will perhaps provide too much coverage in some areas, too little in others, or won't pay off at all because another policy has to pay.

Finally, by buying a limited policy, a narrow coverage contract such as cancer insurance, you are more likely to have problems by the insurance company's attempt to line off and identify the narrow area sought to be covered. For example, some cancer policies will only pay for treatment of cancer, not diagnosis. You run into many strange exclusions that would run counter to all reasonable expectations. Cancer insurance violates still another principle of sound insurance buying. You should try for the policy that has the most favorable benefit-cost ratio, that which pays back the highest percentage of policy premiums and benefits.

There are good, individual medical expense insurance contracts that pay back 95 percent, 90 percent, 80 percent, 70 percent, 60 percent, but often the cancer insurance companies will be paying 40 percent or far less, a less generous payout than the Pennsylvania lottery, and dollar for dollar, more than twice as expensive to get the same benefits to policyholders as a lower cost policy, say at a 90-percent payout ratio.

Cancer policies are not only a gamble and an expensive gamble, but they violate another rule of sound insurance buying. Avoid policies with tricky and deceptive exclusions likely to frustrate expectations and likely to impair the essential purposes of the policy.

Cancer policies are, by their nature, like the old classic medical expenses insurance that won't pay for medical expenses unless or until you are hit by a wild buffalo, while on a Pullman, going south. Not satisfied with an inherently narrow coverage, cancer policies add more tricky exclusions. So you not only have to be hit by a wild buffalo, on a Pullman going south, but the wild buffalo has to be named "Gertrude."

For example, cancer policies may pay for the treatment of cancer, but not for the treatment of the complications of cancer. They may pay only for treatment, not diagnosis, and only for treatment, once there is diagnosis, and not for treatment before diagnosis, and only for treatment if diagnosis is made by a pathologist who examines tissue or blood, even though it may not be medically sound or necessary to undertake a biopsy for pathological examination.

An American Family policy I once examined, acknowledged that problem by permitting diagnosis at time of autopsy, by pathological exam. So, you could wait until death to have your cancer diagnosed, and then be paid for all cancer expenses for up to 10 days prior to autopsy time. [Laughter.]

At least you know when you are going to be stampeded by buffalo, on a Pullman car going south, but you may never know when you are going to be covered or more likely uncovered, by cancer insurance. These tricky cancer exclusions raise questions about the credibility of insurance companies who would employ them. It is significant that not a single blue chip insurance company, the top of the line companies, that deliver the better product, at the lower premiums, from the most stable enterprises, not one of those blue chip insurance companies write cancer insurance.

Still another rule of sound insurance buying is to make your purchases from insurance companies and agents that provide frank and sound advertising and advise. Insurance is a complicated financial instrument which requires a high level of understanding to properly buy and sell. But cancer insurance companies, instead of providing needed counsel and information, do little more than back a hearse up to your door and parade a line of cancer corpses.

You don't even have to look at their funeral-draped brochures. A leading proponent and salesman of cancer insurance admitted, conceded, affirmed, in testimony before this very committee that cancer insurance is nothing more than a high-priced financial rabbit's foot, a fearful superstition, but not a useful product. The cancer insurance spokesman, who incidentally was invited to be here today, but refused, compared cancer insurance to another form of limited protection such as airline insurance for passenger on flights and then made this statement in comparison.

> But I do not buy airline insurance because I am underinsured. I buy it because I feel like if I don't buy it, this may be the very time the airplane is going to fall. I am sure this plays some part in their persistence. They bought the policies. They carried it. They have a superstition about dropping it, I am certain.

Fear is not used simply to catch or inspire interest, it is the whole sales pitch and advertising approach. That is the reason so many buy cancer insurance who can benefit the least from its minimum values, those on medicare who already have adequate supplemental coverage. This phenomenon was documented by the Harrington studies of this House Select Committee on Aging.

When a product is sold irrationally, out of fear, not reason, people buy it who will never benefit from it. For example, cancer insurance has been sold to those who already have comprehensive Blue Cross-Blue Shield contract. So, for each dollar cancer insurance pays, those policyholders simply lose an equal dollar which would have been paid by Blue Cross and Blue Shield. So, a near worthless cancer policy can become totally worthless.

What all this comes down to is this: If you have good basic medical expense insurance, you don't need cancer insurance. If you don't have good basic expense protection, cancer insurance protects you from about 1 percent of your risk of potential medical expenses from all diseases. If you have basic medical expense coverage and want more backup, you should buy an across-the-board backup, not a 1-percent solution or a 99-percent defective solution.

As for remedies, perhaps the most potent and efficient use of resources is to give cancer insurance the publicity it deserves. Informed consumers are not likely to buy cancer insurance. I found my most efficient regulating tool as insurance commissioner of Pennsylvania was being able to publish shopper's guide to give the public the facts and let them decide. We found our guides created an embarrassing glow of publicity that often forced high cost and Mickey Mouse companies to change their ways. I suspect one congressional shopper's guide might do more good than 50 legislative reports.

I would also support measures, some suggested by the Select Committee on Aging, and one which I would like to advocate, is simply to outlaw cancer insurance altogether, to close regulatory gaps that permit some mail order insurers to escape regulation by the States into which their policies are sent, and to encourage States to improve the quality of insurance regulation in the medical expense coverage area.

Incidentally, I support State regulation of insurance, but I don't think there would be anything inconsistent with that by Congress simply outlawing a kind of insurance that is nothing but a Mickey Mouse gimmick and ripoff.

I will make one final recommendation to this committee, ending with a variation on my first recommendation. The best remedy for a lousy product, an overpriced product, a dangerous product, or any other product that does not meet reasonable standards is publicity. If a consumer gets the facts, he will make the right decision. In the meantime, we can contend with overcharges, ripoffs, substandard products and even fraud.

As Senator Philip Hart, who chaired this committee when I last testified before it, has said, "Thirty to forty percent of the consumer dollar buys no value, because of price-fixing, overcharging, fraud and other abuses of the marketplace."

We can survive even if we are free to get information to the public and to freely discuss and criticize abuses and problems in the marketplace. The one thing that is intolerable is a stifling and muzzling of criticism and discussion.

American Family Life, of Columbus, Ga., has apparently decided that it has to end the criticism and discussion of its products. So it has virtually admitted it is going to try to silence the critics by filing libel and slander suits. Earlier this year I was sued by American Family Life Assurance Co. for $5 million for making this statement to a Changing Times reporter: "It makes no more sense to take out a cancer policy then it does to take out a leprosy or a chickenpox policy."

Incidentally, I afterward told a reporter that that was the kindest thing I ever said about cancer insurance. I would say if that is libel, virtually everything insurance experts have said about cancer insurance is libel, everything you gentlemen have said in Congress about cancer insurance is libel, and everything in that great 200-page report is libel. In fact, my statement is quite mild compared to what other critics have said. Ralph Nader, for example, described cancer insurance as one of the biggest frauds in the insurance industry.

My statement was mild, true, and not libelous. The suit filed against me was clearly frivolous. The intention of the suit was perhaps best suggested by the public statement of John P. Amos, chairman and chief executive officer of the American Family Life Assurance Co., at the time he filed another $275 million suit against ABC for a series it did on cancer insurance.

Mr. Amos then said, according to the National Underwriter of January 19, 1980, "We are prepared to answer malicious stone throwers with cannon fire."

When Mr. Amos sued me, he also sued Changing Times and other defendants and made this statement:

> Anyone who did not and does not now take American Family seriously is a fool and should be fully prepared legally to defend its position.
>
> Protecting the integrity, good name and reputation of our company and the equity of our policies from being further maligned must at all times receive top priority. These threats cannot go unanswered and they will not.

Mr. Amos is saying in effect anyone who criticizes American Family Life Assurance Co. has to be prepared to defend legally his position and to face "cannon fire." Mr. Amos has apparently decided it is cheaper to file frivolous lawsuits and to attempt to silence critics than to defend cancer insurance in the marketplace of ideas. I think Mr. Amos knows that he can't defend cancer insurance in the marketplace of ideas. That is why he is not here today.

He once debated me on Good Morning America, and I guess he decided that wasn't the right way to go. The right way to go is not to talk about it, to try to silence critics such as myself and perhaps such as this Congress. I think this all raises some important questions. Should a corporation be able to use its resources to silence critics? It should be noted that there are few if any remedies against this kind of lawsuit however frivolous, and the cost of defense can easily run $25,000 to $75,000 and up. Some law firms wanted a $25,000 down payment before they start talking.

With the debate over the energy crisis, we have seen the kind of budgets that corporations can unlease for public relations and advertising. If the kind of strategy that American Family Life Assurance Co. has adopted is allowed to succeed, we would have turned loose a monster that can damage our rights under the first amendment, the very cornerstone of a free society. It is already difficult enough to get frank and outspoken criticism of shoddy and overpriced products that now overwhelm the market place. Anything that threatens to further stifle that criticism should receive serious scrutiny by this committee, the Senate Antitrust and Monopoly Subcommittee which is concerned with business practices.

Here is one business practice aimed directly at the first amendment and even aimed at Congress itself as one of the defendants in the Changing Times lawsuit is a congressional investigator. It is no coincidence that a company which uses improper tactics to sell cancer insurance will also use improper tactics to silence legitimate criticism. It is no coincidence that a company which uses fear to sell cancer insurance will also use fear as its main tool in attempting to silence legitimate criticism. Thank you very much.

Mr. **Pepper**. Mr. Denenberg, you have made a very able and, I believe, a very strong statement. It occurs to me as a lawyer, I know of cases where when this kind of a suit was filed, a counterclaim was filed for the malicious institution of a civil action.

Mr. **Denenberg**. I will be glad to retain you, Representative Pepper. [Laughter.]

Consider yourself retained. [Laughter.]

Mr. **Pepper**. I am sorry. I would not be available. But it is a matter of great public concern that any company that is engaged in a business vitally affecting the public interest, which is under scrutiny by, for example, congressional committees as well as by State superintendents of insurance, the regulators of insurance, that they might be able to intimidate any public official in making a comment that he believes to be an honest and fair comment—it is a very serious matter to the public interest.

For example, were you sued when you were still a commissioner?

Mr. **Denenberg**. No, I wasn't. I was just sued actually in January. I was joined, along with the representative of your committee, and Changing Times. ABC has been sued.

Mr. **Pepper**. Yes.

Mr. **Denenberg**. The only thing that disappointed me was that ABC was sued for $275 million. I was only sued for $5 million. I think that is libel as far as I am concerned. [Laughter.] That reflects that I am less capable, I guess, than ABC, and I take that with a grain of reservation.

Mr. Pepper. It was at least complimentary to you. That means that the attorney's fees, as you say, can always be very considerable, that means the attorney's fees have to be paid by you, does it?

Mr. Denenberg. That is correct.

I think that is a threat to anyone who wants to speak out, if they can start slapping lawsuits on you. I don't think there is a good remedy. I think that the remedy might be to pay $50,000 to defend yourself and then pay $50,000 to file another lawsuit to vindicate your rights. That is not really practical, in many cases.

Our legal system doesn't provide many practical remedies unless you are prepared to spend a lot of money. Of course, American Family might be able to spend that money. They might consider it a lot cheaper to silence a critic with an expensive lawsuit than to discuss with that critic. Just like Mr. Amos is apparently afraid to be here today to discuss that.

I think when Mr. Amos has tried to defend his product, the results were so unsatisfactory, that he has decided that he can't stand the marketplace of ideas. What he has to do is really intimidate Congress. How can you function if your people sitting right there are being sued in a frivolous lawsuit?

I mean, can you imagine, cancer insurance is like chickenpox insurance, getting sued for that. If that is libelous, almost everything I have said since birth is libelous.

Mr. Pepper. We may well have to extend our inquiry to get into that suit question you just mentioned.

Mr. Denenberg. I think it is important. I think it is especially important in this day and age when you can look in the papers, for example, and you can see the millions of dollars that are being poured into newspapers, television and radio stations by oil companies to influence public opinion.

Now what if those same oil companies would decide what American Family has decided? What if they tried to silence critics by filing lawsuits which are expensive to defend and for which there is no remedy when you get hit?

Mr. Pepper. Mr. Linn.

Mr. Linn. Mr. Pepper, I came here voluntarily to testify as a good citizen. Now I hear what Mr. Denenberg has to say.

I do wish to point out to this committee and to yourself specifically, Mr. Chairman, that this has a very chilling effect on witnesses or on people who may wish to come in the future to any congressional investigating committee in reference to deceptive practices that they feel are deceptive or unfair.

I am not speaking now only about your committee. I personally am now speaking for my own person to tell you that I would have had many serious considerations and thoughts about making the trip from California and appearing before this committee if I felt that I was making myself open to a frivolous or harassing lawsuit that would engage my time and my money and my talents.

I would like to have that protection from this committee on the basis that they would be able to support me and to defend me in the event such an eventuality occurs.

Mr. Pepper. I can assure you that to the extent that it can, our committee will certainly give all the protection needed to witnesses who appear.

I don't know of any actions taken by Congress to protect witnesses who appear at official hearings. Here, this is a hearing of two committees, subcommittees of the Congress of the United States, one from the Senate and one from the House. This is a Senate room in which we are holding these hearings. The staff people here are paid out of Government funds. We are acting pursuant to authority vested in us by the rules of our respective bodies and the like.

This is a public hearing in respect to our effort to protect the public interest. I don't know what the law is about protecting the members of the committee or members of their staff or the like. I know, in general, members are given immunity from what they say on the floor from any kind of requirement to answer in any other forum. I think that extends to other activities in the Capitol and the like. This may cause Congress to look extensively into this very matter of protecting not only their own committees, because I understand our committee has been involved in one of these suits, and also to protect other witnesses like yourself who come here today and to others.

Mr. **Linn.** I would appreciate that, Mr. Chairman.

Mr. **Pepper.** Mr. Denenberg, we understand you wanted to catch a plane.

Mr. **Denenberg.** I will be glad to answer questions if you like.

Mr. **Pepper.** Mr. Kemp wishes to ask a question.

Mr. **Kemp.** Thank you very much, Chairman Pepper.

On behalf of the Senate Antitrust Subcommittee, I would like to follow up your very excellent statement with a couple of questions if I might. As a former commissioner, are you familiar with the activities taken by State regulators across the country in dealing with cancer insurance?

Mr. **Denenberg.** Yes; I am.

Mr. **Kemp.** How would you characterize in general what has been done in the 50-odd jurisdictions?

Mr. **Denenberg.** Well, you have to look at it historically. If you go back to the early 1970's, the whole situation was so bad that you could smell it all the way across the land. Now it is so bad you can only smell it when the wind is blowing. So, there has been some improvement.

I think there are some strong points as your excellent report documents, but it is very weak. Insurance commissioners, I don't think, have done a good job. I, myself, think that on a question like this, if I was a State commissioner of insurance, I would want the policy outlawed altogether. In fact, I think it is very significant that the Insurance Commissioner of Delaware only this month said he would like to have the contract in his State made illegal because he just doesn't have the resources to police all of this gimmick, Mickey Mouse junk.

Theoretically, you could make a cancer insurance policy that wasn't a ripoff, but it would take so much in terms of guidelines and regulatory resources, that it is much easier just to outlaw it. I would certainly favor that solution by Congress. I don't think that is interfering with State regulation.

When I was insurance commissioner I supported Federal no-fault guidelines. I felt Congress could help improve the automobile insurance situation by guidelines and at the same time not get directly involved in the regulatory process. I think if Congress would make cancer insurance illegal, that would not interfere with the ability of the States to regulate themselves.

I think you are leaning on a very thin reed if you wait for the States to act. Because everything that you are talking about is not new. It is 5 years old. It is 10 years old. It is 20 years old. You can wait for the States to act, and maybe they will, 20 years from now. But the question is, how many people like this are going to be lined up at this table in the next 20 years if nothing is done sooner.

Mr. Kemp. Thank you. I would like to follow up with one other point. That chart up against the wall shows that many of these cancer companies keep over half of every dollar paid in by consumers.

American Family, for example, keeps 57 cents out of every dollar. Have you made any review of what happens to the money which is kept by the companies, how it is expended?

Mr. Denenberg. Well, I guess in the case of American Family, the most obvious expenditure would be $1 million to its president. That is where it goes. I think Mr. Amos benefits from cancer insurance. Perhaps salesmen who market it benefit, but I don't think the consumer ever benefits.

I think perhaps one of the reasons these people are up at this table is maybe the money that was supposed to be paid for claims was paid to Mr. Amos. I think it is hard for a company like that to pay $1 million to its president, and still operate as efficiently as it might.

Mr. Kemp. That $1 million figure, is that an annual salary for Mr. Amos, as you understand it?

Mr. Denenberg. As I understand it, he has got some kind of an arrangement where he gets a certain percent of the gross revenues of the corporation with which he is involved.

Incidentally, I might add I think it is appropriate, because when those who manage an organization, an insurance organization, collect a percentage of gross revenue, that is a very dangerous kind of provision, because what it means is they are encouraged to sell, sell, sell, without too much regard to what the profits might be. Now there are some attempts to say that, but I think that is inappropriate, especially in insurance where profits can easily be manipulated by manipulating reserves.

They say you can run an insurance company with total incompetence for years before it would go broke. So, there are all kinds of manipulations possible with an insurance enterprise and, in my opinion, that kind of a provision is dangerous.

Mr. Kemp. Do you know how an annual salary of on the order of $1 million compares with what the chief executive officers of other insurance companies earn?

Mr. Denenberg. Well, certainly it would be far in excess of companies of that size.

Mr. Pepper. I am informed by a member of the staff that witnesses who appear before a congressional committee at a public hearing like this are exempted or immune to suit under the speech and debate clause of the Federal Constitution.

So, apparently you need have no concern about yourselves being the victim of such an action.

Mr. Drinan, have you any questions of Mr. Denenberg?

Mr. Drinan. Thank you, Mr. Chairman.

I want to commend Mr. Denenberg and the others and I am very proud that Massachusetts has banned this type of insurance many months ago. Once again, if I do say so, Massachusetts led the Nation.

Do you think, Mr. Denenberg, that the States may follow the lead of New York, New Jersey, Massachusetts, Connecticut, and New Hampshire and ban this? Do you think there is a reasonable expectation with publicity such as this, with the Consumers Report, with Changing Times and with yourself and with all these people, do you think the insurance companies will recognize that this is a fraud and follow the States or simply withdraw from the business?

Mr. **Denenberg.** No; I don't think so. I think you can overestimate the impact of publicity on legislative bodies. Some of them I described as zoos in the States. I don't think they necessarily react to what is happening in the world. I don't think they are necessarily persuaded by strong studies. It is very difficult to get State legislation. It is quite easy to stop State legislation.

So, I would not—in terms of reason—what reasonable men would do, I would think every State would pass the ban. But that is not going to happen. There has been plenty of time to recognize these abuses. They are really not new at all.

Mr. **Drinan.** I assume therefore that the curve of those taking this insurance is going up. It was 2 million in 1974. This year it is 15 million. You would think, therefore, that the curve would be going up and that only State legislation, along with the recommendations in this report, would suffice to curb this.

Mr. **Denenberg.** Yes. In other words, I think if you look at the States that have banned it, they are progressive States. They are always in the forefront. New York, for example, is the traditional leader in insurance regulation. But I would not expect other States to follow suit.

Mr. **Drinan.** Thank you very much.

I yield my time.

Mr. **Pepper.** Thank you, Father.

Mr. Marks.

Mr. **Marks.** Dr. Denenberg, thanks for being with us. Your candor, as usual, is refreshing. Of course, we are all pleased to hear that no one is going to find themselves in the middle of a law suit today.

Mr. **Denenberg.** I look forward to coming back now that I know I have immunity.

Mr. **Marks.** Right. [Laughter.]

Mr. **Denenberg.** I am ready to have Representative Pepper represent me in that other law suit at any time. [Laughter.]

Mr. **Marks.** Let me ask you about the present situation as far as the States adequately protecting your citizens, particularly in light of policies that are sold through the mail.

Is it possible, is there some possibility that the States, by having these policies registered and examined and certified through the States, could fairly well protect their citizens or do you think that is really an exercise in futility?

Mr. **Denenberg.** Yes. Well, I think the States could do it, but whether they will do it is another thing. You know, most State insurance commissioners are very passive people.

We have an insurance commissioner in Pennsylvania. You hardly hear from him. I set all kinds of precedents, did all kinds of things that were very easy to follow, and yet, the very minute I get out of office, many of them are forgotten. For example, I started the Shopper's Guide series which is a powerful tool when you show how lousy some companies are, when you publish this kind of information.

We had one company that had a loss ratio—was paying out 7 percent. But, for example, my successor has put out a few guides, but he hasn't really followed with what I started. It is really back to business as usual.

So, I think the power is there. I mean, I was astounded with what you could do with the office of insurance commissioner. I found you could turn the world on its end in 24 hours if you wanted to do it. But unfortunately, most insurance commissioners really don't use their powers. They come out of the insurance industry and they want to keep the insurance industry happy. They don't want to rock the boat. They are under all kinds of pressure. So, they need all the help they can get. I think that is why many of the best reforms, in my opinion, came out of the Senate Antitrust and Monopoly Subcommittee with that long history back to Senator Hart. Because they did point out problems. But you can point out problems and nothing will happen. There will be some action. You know, just like with cancer insurance.

This whole thing with cancer insurance and mail order health insurance started in the early 1970's. There were all kinds of big headlines and all kinds of publicity and here it is, 10 years later and we are still in this mess. So, it shows you how slow things are. Anything that Congress could do to speed it up would be much appreciated. And, I think you are in a situation where there is a lot of legislation which Congress could pass that would not be viewed as interference with State regulations. For example, your own study shows that State insurance commissioners want some of these loopholes in mail order insurance marketing closed.

Mr. MARKS. Thank you very much, Dr. Denenberg.

Mr. PEPPER. Mr. Gudger.

Mr. GUDGER. Thank you Mr. Chairman. I want to commend Mr. Denenberg. He adhered to a principle that I heard several times. He who speaks best speaks fast. [Laughter.]

I want to say this, though, I believe I sense in your remarks a strong encouragement for Congress to take some action to limit the mail order situation in this area, and to thus allow the States to regulate themselves.

I also sense that in those States which have held that the legislature of the State, its insurance commissioners, in some instances, under legislative authority have the power to regulate, but do not have the power to prohibit a particular product being sold. That in those instances perhaps—I mean insurance dealing with cancer or specific diseases might be prescribed by regulation in somewhat the same form as automobile liability insurance where only a particular pattern or standards of terms could adhere to those regulations.

Would you speak to that very, very briefly? I understand the prohibition that exists in Massachusetts and New York.

Mr. DENENBERG. Are you talking about what Congress might do?

Mr. GUDGER. I am talking about the legislatures. What the legislatures might do with insurance in this medical field, particularly where specific diseases are controlled and prescribed uniform standards.

Mr. **Denenberg.** Well, I think Pennsylvania, for example, required a law. They actually prescribed minimum standards, so if you write a dread disease policy you have to at least have to pay $100 a day in hospital charges. So, I think there are all kinds of legislation which a State legislature could pass. The laws are very often very unlimited and inadequate. That is why I often use the Shopper's Guide approach, because there was no way to stop an abuse. The only way to stop it was to publicize it.

So, in many States, the authority is inadequate. But the problem is, even if the States had adequate authority there is a question of how vigorously they would use it. You have to remember that most State insurance codes were written by the insurance industry. They represent kind of a common denominator of thinking by the industry and they are really not good, solid codes that provide clear and specific regulatory authority.

Certainly in the health insurance area it is one of the worst, because in almost any other area you can make some intelligent comparisons. If you shop for life insurance, if you shop for auto insurance, if you shop for homeowners insurance, you can compare policies. When you get into health insurance, it is a complete mess. The policies are all over the lot. There is no similarity. It is very hard to shop and compare.

So, I would agree with you that one of the most important things, if possible, would be for States to come up with further legislative authority to regulate health insurance and a prescribed minimum standard.

Now some States have done that, too. But it is a very slow process.

Mr. **Gudger.** Thank you very much. You answered my questions.

Mr. **Pepper.** Thank you again, Mr. Denenberg.

Mr. **Denenberg.** Thank you.

[Mr. Denenberg's prepared statement follows:]

PREPARED STATEMENT OF HERBERT S. DENENBERG

Cancer insurance is an expensive form of junk, gimmick, Mickey Mouse, limited coverage that gives little value for its premium, that is inherently inefficient and uneconomical, that often contains tricky, deceptive and unfair provisions, loopholes, and fine print, that has often been sold not by facts but by appeals to fear, superstition and the irrational, that has been frequently misrepresented in advertisements and sales presentations, and that is often sold to those who are least likely to need its limited protection.

As a result, cancer insurance has been outlawed in some States, including New York, a traditional leader in insurance regulation, and in Connecticut, Massachusetts, New Hampshire, and New Jersey. Other States have considered proposals to do the same, and only a few days ago the Insurance Commissioner of Delaware asked the legislature to make it illegal to write cancer insurance in that State.

Cancer insurance has been widely condemned by State insurance commissioners and by investigations of congressional committees and Government agencies. Cancer insurance has been widely condemned by blue-chip insurers that sell comprehensive and valuable protection and refuse to market this form of junk coverage. And cancer insurance has been widely condemned by a long line of investigations and reports that almost all agree that the coverage is short on economic benefit to policyholders, long on heightening fear as a sales technique, a product for which there are far superior and economical alternatives, and a product whose main value is to those who take the commissions and profits from its sale.

Cancer insurance has one other value. It is useful as an almost perfect illustration of everything that medical expense insurance should not be.

RULE 1. GET COMPREHENSIVE PROTECTION

You need protection against medical expenses whether arising from disease or injury, whether arising from one disease or another, from a common disease or a rare one.

Cancer insurance makes about as much sense as leprosy insurance or smallpox insurance. If you bought policies disease by disease you would soon have a bushel basket full of policies and a thimbleful of money.

There are a couple of problems with buying medical expense insurance on a disease by disease basis. First, you are engaging in gambling, wagering, not insuring. You are betting that you will get one disease rather than another, a bet that you will almost surely lose and end up with uninsured medical expenses.

Second, you are running up needless costs by paying the fixed expenses and commissions for a multitude of policies, in effect obtaining, not a quantity discount but a quantity markup. You're paying for the accounting and bookkeeping of many policies rather than a single one.

Third, by buying many policies, you are increasing the chances that they will not fit together effectively, leaving gaps in some areas and allowing duplication in others.

RULE 2. GET A HIGH COST-BENEFIT RATIO

When you buy medical expense insurance, you not only want comprehensive, across-the-board coverage, but you also want a policy that returns most of the policyholders' premiums in benefits rather than eating them up in expenses or raking them off for profits. In other words, you want a favorable cost-benefit ratio. (In insurance, the ratio of benefits to premiums is called the loss ratio.)

Cancer insurance policies typically return about 40 percent of the premium dollar in benefits, a less generous return than that paid by the Pennsylvania lottery, and only half the return, for example, of a good Blue Cross-Blue Shield policy. In other words, cancer policies may be delivering half the return of some alternatives the marketplace offers.

Even if the return on cancer insurance policies is increased, as it has been in some States due to regulatory requirements, other defects of the policy will not be cured.

RULE 3. AVOID POLICIES WITH TRICKY AND UNFAIR EXCLUSIONS THAT IMPAIR YOUR PROTECTION AND CAST DOUBTS ON THE CREDIBILITY OF THE INSURER

The coverage accorded cancer insurance is narrow enough, but it has been sliced even thinner by tricky and unfair exclusions in the policy. A standard form of one insurer provided: "This policy does not cover any other disease or incapacity other than that resulting from cancer even though such other disease or incapacity may have been complicated, aggravated or be directly affected or caused by such cancer or as a result of cancer treatment."

Not content to pay only for cancer, the company does not do what sound medical expense policies would do—it avoids paying for complications of the disease.

Another provision may provide that no payments may be made until there is positive pathological diagnosis based on tissue or blood examination. A policy may permit the use of post-mortem examination to establish the diagnosis, but then allow for payment of expenses incurred for only ten days prior to the final diagnosis.

The very nature of this type of limited policy is such as to require exclusions that lead to controversy and uncertainty, and result in disappointing expectations.

The kind of unreasonable exclusions cited above cast a shadow not only on the policy itself but the company that would market it.

Even as some of the more unreasonable exclusions and provisions are eliminated, as a result of regulatory pressure and as a result of voluntary action by the insurer, the problem of drawing lines to define the covered and uncovered in such limited policies will persist.

RULE 4. BUY FROM A BLUE-CHIP INSURER IF AT ALL POSSIBLE

In buying a long-term contract, that depends on the financial strength and good will and equity in claims payments of a company, it is important to select blue-chip insurers who can be counted on in the long run.

Based on my knowledge of the marketplace, there isn't a single blue-chip insurer writing cancer insurance. By blue-chip insurer, I mean those companies with the best reputations for good management, quality products, competitive products and financial stability.

Even applying more modest standards, cancer insurance companies are usually less than you'd want to insure with. Insurance experts commonly suggest going with companies that have one of the two top ratings issued by *Best's Insurance Reports*, a leading authority on the financial strength of insurance companies.

In 1976, the Madison (Wisconsin) Capital Times checked the 20 insurers writing cancer insurance in Wisconsin. At the time, not one of the 20 insurers had a top rating and only 1 of the insurers had one of the two top ratings.

At the present time, there are few companies with the top Best Rating that write cancer insurance. But there may be good reason why over the years this kind of coverage has seemed to attract, on the average, the lower quality companies.

It may well be that the highest quality insurers have not written cancer insurance because they see it as so many else have—as a form of junk insurance that will not serve the policyholders well.

RULE 5. BUY FROM INSURERS THAT PROVIDE FRANK AND SOUND ADVICE AND ADVERTISING AND ADVISE THEIR POLICYHOLDERS WELL

Insurance is complicated merchandise designed to serve a vital economic purpose. It requires frank and sound advice and advertising if it is going to be properly purchased and evaluated.

The American public does not have to be terrified, frightened or brow-beaten in order to purchase insurance. They have demonstrated they are one of the most insurance conscious and insurance buying people in history.

Yet, all to often, instead of providing frank and sound advice, cancer insurers have attempted to mislead and frighten their prospects.

One of the classics in the sell-by-fear approach is the Union Fidelity Life Insurance Co. brochure that says: "The same thing that happened to Babe Ruth, Nat 'King' Cole, Walt Disney, Sophie Tucker, Gary Cooper, Babe Zaharis, Spike Jones, Chet Huntley, Jack Benny, Vince Lombardi, and Gypsy Rose Lee * * * could happen to you: CANCER."

"It's sad but true * * * the prominent people you just read about all had cancer. Millions of others are being struck by this horrible disease. Most of the victims are people like you and me * * * not famous or prominent, but with the same will to live."

Needless to say, the brochure is printed on a black, funeral-like background, along with everything but the dirge. There may be some fear involved in the sale of all insurance, but with cancer insurance it sometimes seems to be the central and only theme.

Most observers of the insurance scene will probably agree that cancer insurance is sold on the basis of fear rather than reason. Even a leading proponent and salesman of cancer insurance, John Amos of American Family Life Assurance Co. of Columbus, Ga., told the Senate Subcommittee on Monopoly and Antitrust that his product is sold on the basis of fear and superstition.

He compared cancer insurance to other forms of limited protection such as airline insurance for passengers on flights and then made this statement: "But I do not buy airplane insurance because I am under-insured. I buy it because I feel like if I don't buy it this may be the very time the airplane is going to fall. I am sure this plays some part in their persistence. They bought the policy, they have carried it and they have a superstition about dropping it, I'm certain." (1972 Hearings).

What Mr. Amos admits, before this very committee, is that he is selling a high-priced financial rabbit's foot, a fearful superstition, not a useful insurance contract.

Fear is not used simply to catch or inspire interest, it is the whole sales pitch and advertising approach.

That's the reason so many buy cancer insurance who can benefit the least from its minimum values—those on medicare who already have adequate supplementary coverage. This phenomenon was documented by the hearings and studies of the House Select Committee on Aging.

RULE 6. IF YOU NEED MORE MEDICAL EXPENSE INSURANCE BUY A SUPPLEMENTARY POLICY THAT BACKS UP YOUR BASIC PROTECTION ACROSS-THE-BOARD

There is room for supplementary policies to back-up basic insurance and provide additional amounts of protection. For example, medicare leaves substantial uninsured gaps in the protection provided senior citizens. A whole industry has developed to fill those gaps.

Insurance experts are unanimous in the opinion that a good medicare supplement should provide coverage for those gaps on an across-the-board basis, not disease by disease, or condition by condition.

Senior citizens, above all others, should be aware of the need to buy insurance efficiently, to supplement across the board, and to avoid ending up with multiple, expensive, conflicting, duplicating policies.

The same principles apply to buying supplementary protection for the rest of the population. By applying these principles, the consumer will not only get protection against all injuries and diseases, but will also get it more efficiently and economically, with less chances of dispute and litigation, and with greater chances of getting a quality company. The consumer will also be provided with a broader range of services for treatment in and out of the hospital.

For example, in Philadelphia, a Blue Cross subscriber can buy a $10,000 major medical (which increases to $20,000 in 5 years), for as little as $3.40 a month for an individual and $6.80 a month for a family. Still another possibility would be to buy a jumbo major medical with a large deductible. One major insurer, for example, markets a $250,000 benefit policy, with a $10,000 deductible for $117 a year for males ages 22 to 41, and $130.50 for females of the same ages, with higher premiums at higher ages. (The Blue Cross-Blue Shield contract, mentioned above, has the same premium at all ages.)

Sound insurance principles, for many different reasons, point away from cancer insurance. Those that have good medical expense insurance do not need cancer insurance. Those that do not, should get a good basic contract and supplement it across the board if necessary. Cancer insurance, at best, provides an interesting form of speculation for those who want to take a gamble at selecting the disease they are likely to get.

That's what the New Hampshire Department of Insurance had in mind when they banned cancer insurance and said: "Of 28,070,000 hospital discharges in the United States in 1968, malignant neoplasms (cancer), constituted the diagnosis in 1,044,000 cases or 3.7 percent." That percentage is up since then but not enough to substantially change the picture.

Later and more comprehensive figures from the National Center for Health Statistics show that neoplasms, both benign and malignant (cancerous), account for only 5.3 percent of the total expenditures for medical care. If benign neoplasms were subtracted, the percentage would be even smaller.

Other adjustments could be made in the data. But however these statistics are manipulated, the results are not radically altered. It should also be noted that one major cancer insurer claims to pay no more than 40 percent of the patient's cancer bills. So that would mean cancer insurance would only be paying for a few percent of total cancer costs.

SOME SUGGESTED REMEDIES

1. While Insurance Commissioner of Pennsylvania from 1971 to 1974, I found the most effective regulatory tool that I had was the publication of shopper's guides to various forms of insurance and health care. (See appendix I, an article on the guides; and appendix II, some of the Guides.)

This did not require legislation, or slow-moving regulatory action. We found direct and specific information to the consumer was the quickest way to inform and improve the marketplace.

For example, after publishing our "Shopper's Guide to Life Insurance" many companies listed as high-cost companies actually changed their premiums and wrote to the Department asking to be taken off the high-cost list.

We also found that the "Shopper's Guide to Health Insurance" also had great impact on the marketplace, because the purchases there, for the typical consumer, are among the most difficult of any form of insurance.

By giving the consumer the facts, we were able to get more and more buyers to make intelligent decisions in the marketplace, and to avoid the numerous deceptions and pitfalls.

The purposes of insurance regulation are to achieve sound and competitive markets, and consumer information did that faster than any conventional regulatory approach.

So I would urge Congress and this committee in particular to fully publicize the nature of cancer insurance and the alternatives in the marketplace. Over the years, legislative committees turn out fat, unreadable and unread reports that do not directly influence the consumer or inform him.

I'd suggest that this committee, before it bothers with a lengthy report on this subject, or as an adjunct to its report, publish a "Consumer's Guide to Cancer Insurance."

2. Another approach we attempted in Pennsylvania was to ban cancer insurance altogether as inherently uneconomical and deceptive. We lost in a court battle, with a decision that we lacked adequate authority to impose a ban.

By now five States have actually banned cancer insurance. This approach has not lost favor, and only in the last few days, the Insurance Commissioner of Delaware has proposed a legislative ban of cancer insurance.

The Delaware Commissioner, David Elliott, said in proposing the ban that the prohibitive cost of establishing regulatory guidelines and for personnel to monitor the insurance companies' loss ratio for cancer policies make any other approach too costly.

This conclusion suggests the inherent deficiencies of the product. It may also suggest that in smaller States, with more limited regulatory resources, an outright ban is not only the best approach but may be the only approach.

About the only argument against the use of a ban as a regulatory technique is that the public should be free to buy foolish products. One insurance expert put it this way: "My reluctance stems from my unwillingness to restrict the freedom of people to make irrational purchases."

This philosophy may be persuasive in some areas of the marketplace. But insurance, for good and sufficient reason, has been subject to comprehensive regulation to assure a sound and reasonable product. Both the premium and the contract must meet regulatory tests. There is no reason why we should not subject the product itself, which results in questionable rates and policies, to regulatory tests.

The consumer will be left with ample freedom to make all of the "irrational purchases" in other areas of the marketplace, not subject to insurance regulation.

I would continue to support a ban of all cancer insurance policies by each State. I prefer to see State insurance regulation continue, however, so I would hesitate to propose any direct Government regulatory action.

As was the case with the no-fault controversy, another possibility is the promulgation of Federal guidelines, with the regulatory controls and administration left to the States.

A flat prohibition of cancer insurance by the Federal Government, that is, by congressional action, would leave State regulation intact, and would certainly not require the creation of a Federal regulatory commission or apparatus.

If the Federal Government is to intervene, a ban would create fewer complications and conflicts within the State-Federal system than attempting to set up minimum guidelines for the marketing of cancer insurance.

3. The gaps in the regulation of mail-order insurance, especially those policies involving group policies and trusts, is another area of abuse where Federal action might play an important role. For example, group insurance policies may now be marketed across the United States without meeting the policy regulations of the States into which they are sent. The problem is most acute in the area of association groups rather than those involving employers and unions.

The mails could be closed by Congress to insurers who send policies that do not meet local regulatory requirements of the States into which the policies are sent.

This kind of proposal would be supported even by ardent advocates of State regulation, as it strengthens it, rather than weakens it, even though the source of action is the Federal Government.

4. I will make one other recommendation to this committee, ending with a variation on my first recommendation.

The best remedy for a lousy product, an overpriced product, a dangerous product or any other product that does not meet reasonable standards is publicity. If the consumer gets the facts, he will make the right decision.

We can contend with overcharges, rip-offs, substandard products and even fraud. As Senator Philip Hart, who chaired this committee when I last testified before it, has said—30 to 40 percent of the consumer dollar buys no value because of pricefixing, overcharging, fraud and other abuses of the marketplace.

We can survive even that if we are free to get information to the public and to freely discuss and criticize abuses and problems in the marketplace. The one thing that is intolerable is a stifling and muzzling of criticism and discussion.

American Family Life of Columbus, Ga., has apparently decided that it has to end the criticism and discussion of its product. So it has virtually admitted it is going to silence its critics by filing libel and slander suits.

Earlier this year, I was sued by American Family Life Assurance Co. for making this statement to a Changing Times reporter: "It makes no more sense to take out a cancer policy than it does to take out a leprosy policy or a chickenpox policy."

If that's libel, virtually everything insurance experts have said about cancer insurance is libel. In fact, my statement is quite mild compared to what other critics have said. Ralph Nader has described cancer insurance as one of the biggest frauds in the insurance industry. Many others have been equally outspoken.

My statement was mild, true and not libelous. The suit filed against me was clearly frivolous. The intention of the suit was perhaps best suggested by the public statement of John B. Amos, chairman and chief executive officer of the American Family Life Assurance Company, at the time he filed another $275 million suit against ABC for a series it did on cancer insurance.

Mr. Amos then said, according to the National Underwriter of January 19, 1980: "We are prepared to answer malicious stone throwers with cannon fire."

When Mr. Amos sued me, he also sued Changing Times and other defendants and made this statement: "Anyone who did not, and does not now, take American Family seriously is a fool and should be fully prepared, legally, to defend his position. Protecting the integrity, good name and reputation of our company and the equity of our policies from being further maligned must, at all times, receive top priority. These threats cannot go unanswered. And they will not."

Mr. Amos is saying, in effect, anyone who criticizes American Family Life Assurance Co. has to be prepared to defend legally his position and to face "cannon fire."

Mr. Amos has apparently decided it is cheaper to file frivolous lawsuits and to attempt to silence critics than to defend cancer insurance in the marketplace of ideas.

This raises some important questions. Should a corporation be able to use its resources to silence critics? It should be noted that there are few if any remedies against this kind of lawsuit, however frivolous, and that the costs of defense can easily run $25,000 to $75,000 and up.

With the debate over the energy crisis, we have seen the kind of budgets that corporations can unleash for public relations and advertising. If the kind of strategy that American Family Life Assurance Co. has adopted is allowed to succeed, we will have turned loose a monster that can damage our rights under the first amendment, the very cornerstone of a free society.

It is already difficult enough to get frank and outspoken criticism on shoddy and overpriced products that now overwhelm the marketplace. Anything that threatens to further stifle that criticism should receive serious scrutiny by this committee which is concerned with business practices. Here is one business practice aimed directly at the first amendment, and even aimed at Congress itself, as one of the defendants in the Changing Times lawsuit is a congressional investigator.

It is no coincidence that a company which uses improper tactics to sell cancer insurance will also use improper tactics to silence legitimate criticism.

And it is no coincidence that a company which uses fear to sell cancer insurance, will also use fear as its main tool to attempt to silence legitimate criticism

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Mr. **Pepper.** I appreciate your coming here.

We will continue with the witnesses.

STATEMENT OF MARC H. BOTZIN

Mr. **Botzin.** Mr. Chairman, members of the committee, my name is Marc H. Botzin. I practice law here in Washington, D.C. I was asked to relate a case that I handled involving cancer insurance claims practices.

In November 1978, I began to represent the widow of Earl Perrie, a District resident who died of cancer in September 1978. Mr. Perrie had a malignant tumor on his lung that grew out through his chest wall resulting in respiratory failure.

During his life, Mr. Perrie owned a cancer insurance policy written by the Mutual Protective Insurance Co. of Omaha, Nebr. Mr. Perrie purchased the policy in 1975, when he was 68 years of age. I have previously submitted a copy of the policy to Mr. Phillips. I would ask the policy and my written statement I gave him be offered for the record.

[The material referred to is on file with the committee.]

Mr. Pepper. Without objection, so ordered.

Mr. Botzin. The policy I mention is typical from the policies that I have read, and virtually identical to a policy that I have seen by American Family Life. It provides essentially for daily benefits for hospital confinement and home confinement following a hospital admission for treatment of cancer.

Mr. Perrie had a tumor that was first diagnosed in January 1978, and he was hospitalized on three occasions during that year. On each occasion, the admitting diagnosis was cancer. He received radiation treatments and chemotherapy for the very same growth that eventually killed him in September.

His wife at that time had submitted claims as they arose to Mutual Protective and asked them to pay the daily benefits as well as the scheduled benefits that the policy allowed for the treatment that he received. All during his life the insurance company refused to pay the claim. When she came to me in November, and I reviewed the policy, it was apparent that Mr. Perrie's condition was not diagnosed as a malignancy in accordance with the policy, which again is typical in that it requires a pathologist's laboratory diagnosis of malignancy. The clinical diagnosis that had been made throughout 1978 did not satisfy the policy. At that point, no offer at all was forthcoming from the carrier.

Around December, the insurance company offered to pay approximately a third of the value of the claim. The way they did that was to send one of their claim agents from Nebraska, unannounced to my office, who was waiting in my waiting room with a checkbook when I walked in around Christmastime.

He suggested to me that the money might pay Mrs. Perrie out during Christmas. He gave no further explanation for the basis of the offer. He phrased it in round numbers and he left. We naturally refused the offer.

Following that episode, I went over to the hospital and spoke with the pathologist who eventually did diagnose the malignancy during the last hospital admission which was about 20 days before the man died. It was his opinion, as well as the diagnosing pathologist's opinion, that the policy was inherently unreasonable in two respects. The first respect was because of the requirement of a pathological diagnosis, which in many cases, and in particular, in the case of my client's late husband, it probably would have killed him if they opened him up to take sufficient tissue samples to prove malignancy.

There were about 14 or 15 earlier pathology reports that were all suggestive of malignancy, but the way they were termed was "irregular cells, suggestive of malignancy," and they all suggested further and other biopsies, all of which the treating surgeon believed were dangerous to the health of the patient.

Eventually, they did pay the entire amount of the claim, which was about $10,000. The reason they did that was because I was lucky enough to have cooperative doctors who would provide me with reports without charging me the customary report fees. I also threatened them with a lawsuit and taking the case to the media, newspapers, and so forth.

It took approximately 8 months back and forth with the insurance company to get them to pay the face amount of the claim, and quite frankly, the reason that we didn't sue them earlier was because my client's age was about 70 years old. She was in ill health. Under the literal terms of the policy, and no local precedent to show that the terms of the policy were unreasonable and unconscionable as a matter of law, it seemed to be a losing proposition, because our estimates would be that it would take about 3 to 5 years to take the case through the local courts and the local appellate courts.

I would point out that an interesting sideline here was that the insurance carrier who was again, in Omaha, consulted with a pathologist at Creighton University for the purpose of showing the so-called reasonableness of the pathological diagnosis.

I was fortunate enough to get a copy of the pathologist's report, which doesn't deal at all with my client's situation, but merely makes a bland recitation that there are many people throughout the country who are treated for malignant disease who don't have it. Because of that, he believes it is essential that a 100-percent sure diagnosis of malignancy be rendered before the policy should pay.

Because it has been asked of other people who have testified here, I would point out that the monthly premium for this policy was $8. It was purchased by Mr. Perrie in connection with a medicare supplement policy which in itself paid a lot of the hospital charges. But there were somewhere in the neighborhood of $10,000 or $11,000 in daily benefits that we computed to have been due, of which the insurance carrier initially refused to pay any amount. Thank you.

Mr. Phillips. Thank you, Mr. Botzin.

You mentioned the pathology reports that were required under this policy. Did Mr. Perrie have to pay for these out of his own pocket, as Mr. Linn did, or is that covered under the policy?

Mr. Botzin. Well, customarily, the client would pay for them. I have never seen a policy yet that covers the cost of an evaluation or report from any physician. Customarily, when they are submitted with a bill, they are turned down in this type of insurance as well as casualty insurance.

Mr. Phillips. Does Mr. Perrie's policy specifically exclude cancer benefits when treatments occur prior to positive diagnosis by a pathologist?

Mr. Botzin. Yes; it does. In his particular case, he was admitted in April, June, and August. Since the growth had actually grown through his chest wall and they could take sufficient tissue samples to reach the diagnosis, they agreed to pay for that particular confinement and the 10 days following it that he lived. But they denied some 73 odd days of prior confinement.

Mr. Phillips. I understand that they have latitude under the policy as written to do that?

Mr. Botzin. Exactly. The policy specifically provides that the earlier admissions are not covered.

[Mr. Botzin's prepared statement follows:]

Prepared Statement of Marc H. Botzin

Shortly following the death of Earle Perrie on September 18, 1978, at age 71, this office was consulted by the widow of the deceased in connection with recovering benefits under a cancer insurance policy. This policy, a copy of which is attached, provides for daily benefits for hospital and home confinement due to cancer, as well as additional benefits for certain medications and surgical procedures.

Mr. Perrie died of respiratory failure due to a bronchogenic carcinomae which had grown through his chest. According to the death certificate, the cancer had been present for approximately 8 months.

Mr. Perrie had been hospitalized on three occasions during 1978 for the treatment of cancer. He spent approximately 73 days in the hospital with intervening periods of home confinement. During each hospital admission, biopsies and tissue samples were taken to confirm the clinical diagnosis of cancer. According to the numerous pathology reports, the tissue samples were suggestive of malignancy but not conclusive. It was not until Mr. Perrie's third admission that a conclusive diagnosis of malignancy was made by a pathologist in conformance with Part 2 of the insurance policy.

After assembling documentation for this claim, the insurance company offered a settlement which appeared to pay benefits relating only to the third period of hospital confinement. The policy language prevented recovery for confinement related to the earlier two hospital admissions due to the failure to positively diagnose malignancy by laboratory methods. However, as the decedent was treated for a cancer condition which eventually killed him, and had been present prior to his first hospital admission, we question the purpose of the policy provision and the carrier's motive in invoking it. After consulting with the treating physician and the diagnosing pathologist, we are convinced that the requirement for a laboratory diagnosis of malignancy in a great number of cases is medically unreasonable. In fact, the treating physician was amazed that the insurance company would question his diagnosis after reviewing the patient's chart.

We were engaged in settlement negotiations with the insurance carrier from December 1978, through May 1979, at which time the claim for benefits was settled. The insurance company had been in possession of the relevant hospital records since the fall of 1978, and had consulted with a pathologist at Creighton University in an effort to document their denial of this claim. We point out these facts due to a statement contained in an article in the Washington Post on June 11, 1979. This article states that the director of claims for Mutual Protective Insurance Company, with whom we negotiated the settlement of this claim, said "his company ultimately would have waived the provision requiring pathology confirmation of Perrie's condition". We cannot imagine when the company intended to make such a waiver, as they never did.

Mr. Phillips. Mr. Chairman, I have questions for the other witnesses.

Mr. Pepper. Go right ahead.

Mr. Phillips. Mr. Schmidley, did the Mid-South Insurance Co., the carrier for your client, Mr. McGee, cite any evidence of any kind of a conclusion that Mr. McGee had cancer before April 1, 1978, the date the policy was purchased?

Mr. Schmidley. No, Mr. Phillips. The only evidence that they cited to support their preexisting condition or illness contracted prior to the effective date of the policy was the fact that Mr. McGee had a mole on his back.

During the course of the deposition testimony, the senior claims examiner for Mid-South stated that he felt when the mole developed into a melanoma was irrelevant to his determination that it was an illness which was contracted prior to the effective date of the policy.

Mr. **Phillips.** That might be interpreted by reasonable people as a sort of a seat of the pants judgment on the part of the insurance company.

Does the policy give them that kind of latitude?

Mr. **Schmidley.** Well, I would say the policy does give them that kind of latitude to interpret as they wish the term "illness contracted prior to the effective date of the policy."

I think when that phrase is used, and when the examiner who is going to review the claim knows what the law is as to a preexisting condition, then there is not any latitude. They can either determine whether they have a reason or a basis for denial or they can pay the claim.

Mr. **Pepper.** Would the gentleman yield right there?

It would seem to me that even assuming that language which is probably clearly unfair to the covered person, that the insurance company would have the responsibility of showing that the malignancy began prior to the time that the policy was taken out.

Mr. **Schmidley.** Mr. Chairman, that is the position we are taking.

Mr. **Pepper.** They denied that?

Mr. **Schmidley.** They have denied the claim; yes, sir.

Mr. **Pepper.** Thank you.

Mr. **Phillips.** Chief Meiers, did the language of Mr. Sturgeon's insurance policy in any way contradict what the agent told him orally in 1968 or 1969?

Mr. **Meiers.** That is correct.

Mr. **Phillips.** The language of the policy did not contradict the statement that even if Mr. Sturgeon was confined in a VA hospital, a confinement benefit would be paid?

That is not contradicted by the language of the policy?

Mr. **Meiers.** No, sir.

Mr. **Phillips.** According to that group policy, the confinement benefit would come to $50 a day for the first 7 days of confinement, and $30 a day thereafter.

What was the total amount that Mr. Sturgeon claimed?

Mr. **Meiers.** Mr. Sturgeon's total claim in both hospitals ran about $4,200.

Mr. **Phillips.** What does that consist of?

Mr. **Meiers.** In the VA hospital a quotation of about $1,800, in benefits, plus the other hospital, in Helena, $1,000 even.

Mr. **Phillips.** So that is a private hospital that has nothing to do with the VA. Was any amount of that claim paid?

Mr. **Meiers.** No, sir, it has not been paid.

Mr. **Phillips.** What was their basis for denying that claim?

Mr. **Meiers.** They didn't give any reason as far as I know.

Mr. **Phillips.** I understand that Mr. Sturgeon is suing American Family Life in the State court in Arkansas. What amount is he suing for?

Mr. **Meiers.** $500,000.

Mr. **Phillips.** Punitive damages?

Mr. **Meiers.** Yes, sir.

Mr. **Phillips.** Mr. Meiers, you state in your testimony that Mr. Sturgeon's policy cannot be changed without Mr. Sturgeon's permission.

Mr. Sturgeon, I wonder if you could answer this for me. Did you ever grant such permission to the company?

Mr. **Sturgeon.** No; I did not.

Mr. **Phillips.** Thank you.

Mrs. Sobiesiak, you state that you bought your cancer policy from Union Fidelity Life Insurance Co. of Pennsylvania on April 22, 1979.

You have a 30-day waiting period in the policy before your coverage actually began. The cancer, it is my understanding, wasn't diagnosed until June 1.

Mrs. **Sobiesiak.** June 1, right.

Mr. **Phillips.** It is some 40 days after the effective date of that policy.

Mrs. **Sobiesiak.** Right.

Mr. **Phillips.** So, what exactly was Union Fidelity's basis for denying your claim?

Mrs. **Sobiesiak.** Well, on the policy it says the member shall become afflicted with cancer which is manifested as herein defined in the entire lifetime of such family member on or after the 30th day following the effective date of this policy.

Now the doctors claim that we knew that he had the cancer which we definitely did not. They said that any prudent person would seek diagnosis and care and treatment if there was any abdominal distension or disurea.

But, any normal person will know that a person usually associates cancer with pain, loss of weight and a lot of bleeding, loss of appetite. My husband had none of these outside of that one incident of a few drops of blood in his urine.

He had the distention, yes, but as I said before, the doctors claimed that it was because he was eating too much.

Mr. **Phillips.** So the company in essence was saying that he should have known that he had cancer at the time he took out the policy?

Mrs. **Sobiesiak.** Yes; that is exactly what they are telling me.

Mr. **Phillips.** Do they ever offer any evidence to that effect?

Mrs. **Sobiesiak.** None.

Mr. **Phillips.** The first time cancer showed up was on the 1st of June?

Mrs. **Sobiesiak.** It was such a shock to us, you can't believe.

Mr. **Phillips.** I understand you appealed your case to the Pennsylvania State Insurance Commission.

Mrs. **Sobiesiak.** We did.

Mr. **Phillips.** Have they taken any action on your claim?

Mrs. **Sobiesiak.** Oh, yes, yes, yes. Mr. Dunn, the chief investigator, is going to have a meeting with the Union Fidelity Insurance Co.

Mr. Thomas Finnegan is supposed to meet with them.

Mr. **Phillips.** What has Mr. Dunn—what is his position?

Mrs. **Sobiesiak.** Oh. He is the chief investigator of the insurance commissioner, in Harrisburg.

Mr. **Phillips.** What position is he taking on your claim? He is supporting it?

Mrs. **Sobiesiak.** Oh, definitely. He is 100 percent in agreement with us. I didn't sort of like what Mr. Denenberg said that nothing is being done. It is being done. Mr. Dunn is breaking his back for us. He really is.

Now, as a matter of fact, one time he wrote to the company. He said, "I do not mean to be facetious, but really, every one of the symptoms of pain, increase in abdominal girth, hemotheria, urinary urgency, and disurea would be present in me if I were to drink a few extra bottles of beer for a few weeks."

Mr. **Phillips.** That is fine.

I wonder if you would submit that material for the record?

Mrs. **Sobiesiak.** With pleasure.

[The matter referred to above can be found in the appendix.]

Mr. **Phillips.** Thank you.

Mr. **Pepper.** On behalf of Senator Metzenbaum and of our committee, I wish to thank every one of you in the warmest way for coming here today and remaining as long as you have and giving us this very valuable testimony.

We appreciate it. It is excellent testimony and bears very critically upon the concerns we have about this kind of policy.

So, we want to thank every one of you for coming and wish you a safe and pleasant trip home.

Thank you very much.

Mrs. **Sobiesiak.** Thank you for listening to us.

Mr. **Sturgeon.** Thank you.

Mr. **Meiers.** Thank you.

Mr. **Schmidley.** Thank you, Mr. Chairman.

Mr. **Botzin.** Thank you, sir.

Mr. **Pepper.** Thank you.

Now, we would like to call to the witness stand our concluding witnesses, Mr. Alan Wright, former director of field audit, Massachusetts Insurance Department; Mr. Arthur McCabe, Boston attorney, and Mr. Howard Petricoff, assistant attorney general for Ohio.

PANEL OF REGULATORS:

STATEMENTS OF ALAN WRIGHT, ARTHUR McCABE, BOSTON, MASS., AND HOWARD PETRICOFF, COLUMBUS, OHIO

Mr. **Petricoff.** I offer my statement and two memoranda the staff requested for the record.

Mr. **Pepper.** Without objection, they will be received.

[The memoranda referred to above can be found in the appendix.]

Mr. **Petricoff.** I would like to present to the committee my statement tomorrow in written form.

Mr. **Pepper.** Very good.

Mr. **Petricoff.** I will dispense with reading it.

Mr. **Pepper.** We would like you to do that.

Mr. **Petricoff.** Thank you.

The points that I think I was going to make today, and the purpose was to discuss circumstances and the findings of the attorney general of Ohio's inquiry into the cancer policy offered to the State employees, the point that has not been touched on so far is a discussion of the special problems of group insurance and special cancer riders and special cancer policies.

As for particulars on the policies offered to State of Ohio employees, we ran into three problems and I think ones that will crop up with anyone with group insurance and in the health and accident field. That is a sizable portion of the market.

In the general health and accident policy offered to all State of Ohio employees, there is a coordination of benefits clause. The purpose of that is to reduce more than 100 percent collection on any health or illness claim.

Now the economic basis of group insurance is that you have a group of people who offered their particular needs as a group. They more or less disperse their risk of medical costs among all the members of the group. One of the advantages of group insurance is that the group can take steps to minimize the cost. In these days of rising health care, that is very important. Coordination of benefits clause is one that is frequently found in group policies. What it says is that if you would have more than 100 percent collection for any medical reimbursement, the central policy group claim can reduce its payments by the amount you are going to receive from other group insurance or other types of insurance.

That way, no one has an incentive to claim illness. On the other hand, we are still insuring that all the members of the group will in fact get the medical coverage they need in times of a medical necessity. Because most of the policies that were offered—the cancer policies offered—the same type of benefits were covered under the general group health and accident plan, a person holding both of them would achieve nothing more than a reduction in their payments they would have gotten from the group. That was the real heart of the memo that the attorney general sent to the director of administrative services.

The other thing that I think is very important is the concept of group. While the cancer insurance that was offered had all of the trappings of group, there was a deduction from the wages to pay the premiums and they got information that all said State of Ohio employees, in fact, the cancer insurance was not true group because the premiums were not based on the medical history of the State employees. It was just a discount for those administrative services. In fact, when we approached the companies that were offering the cancer insurance to produce the true medical histories involved—the true ratio of benefits paid out to the group—were told that was impossible.

Now, reviewing the material that was on file for the company as a whole, we noticed that the companies were paying out 34 cents on the dollar for 1977, and 35 cents on the dollar in 1978, while the normal rate for the industry for group accident and health is about 80 and for the Blue Cross and Blue Shield general plan it is about 90 in Ohio. That was the other evidence that was in the memo.

In summary, those are the kinds of problems that group insurance has. I think it is something the committee ought to consider.

Mr. PEPPER. Thank you very much.

Mr. Wright.

Mr. WRIGHT. Thank you, Mr. Chairman.

I do not have a formal, written statement to present. I think the copies of the examination report which you already had received are as good a written report as I can make.

My name is Alan Wright. I worked at the division of insurance as the assistant director of field audit from November 1976, until October 1978. I was the director of field audit from October 1978 to May 1979. At various periods I was also acting deputy commissioner.

In the summer of 1978, Commissioner Stone directed that we examine four companies that specialized or sold cancer insurance. These were Washington National, American Family, Union Fidelity, and American Income.

We decided we would not do these examinations with our in-house people. We did not have sufficient depth to do this. So we hired three CPA firms—Price Waterhouse; Touche, Ross; and Coopers and Lybrand—and we hired three outside attorneys. We conducted an extensive search and then hired the three best ones we could find. We hired a marketing research firm. We interviewed several of them and hired what we considered was the best one. After we put the team together, we constructed an audit program. This was a comprehensive and detailed document which you also have copies of, which outlined the steps which we would take to examine these companies.

We began the field work in August, at Washington National. We completed it in September. American Family, we were there from September to October; Union Fidelity, from August to October; American Income, from October through November.

Mr. PEPPER. Would you give us your conclusions from those investigations?

Mr. WRIGHT. I will summarize the findings. Mr. McCabe, my colleague, will go into some more detail on these findings.

We found that the advertising was deceptive, misleading, incomplete, and unclear. We found that the sales techniques emphasize fear and cost. They emphasize the maximum possible benefits. They did not emphasize specifics. There was little or no agent training, little or no agent control conducted by the companies.

Since two of the companies sold to employees or to union members, there was always the implied endorsement that the union or company had given to the policy. Complaint handling at the companies tended to be inadequate. It was not uniform. There was no central review or control at any of the companies we examined.

In the claims area, the loss ratios were low.

American Family, 43 percent; American Income, 25 percent; Union Fidelity, 18 percent. The average payout at Union Fidelity was $330 on the claims examined. At American Income, it was $1,400. At American Family, it was approximately 36 percent of the items that were covered, and 24 percent of the items that were claimed.

Union Fidelity advertised very strongly, collect up to $200,000. There was no way that one could get the maximum benefit of $200,000. If you used the company figures you would have to have been hospitalized for over 3 years, and 3 years is the cutoff period on the policy.

American Family had a policy that pushed extended 90-day coverage. This was really illusory. The average stay of the claims we examined was 13 days. There was only one claim that lasted over 30 days.

The policyholders at Union Fidelity were in their mid to late seventies. At American Family they were in their midfifties. Some 95 percent of the policyholders had other coverages. Fear was the prime motivator in these people buying these policies.

At American Family all the policyholders seemed to know that they had a policy. But two-thirds of them didn't understand the policy or what the coverage benefits would be. At Union Fidelity, only two-thirds of the people even knew they had a policy, and three-quarters of the people did not understand what the policy covered.

After the field work was completed, we drafted the reports. We got Commissioner Stone's approval. We sent them to the companies for their responses.

The response we got back from Washington National said: "You had no right to examine us, besides which we never made very many sales in Massachusetts. Furthermore, we discontinue sales."

American Family's response was:

> We aren't admitting anything, but we are not going to argue with you because we want to continue to sell insurance in the Commonwealth of Massachusetts. So, we will make whatever corrections you say we have to.

American Income did not respond because they had a minor misunderstanding.

Union Fidelity waited until the response period was up. And then they said they could not meet the response period. They hired a local attorney with good connections who came up, went to the insurance commissioner and got an extension of the time in which they should respond. They have submitted their response. We were in the process of working on our responses to what they had submitted.

Three reports were published in mid-February 1979—all but Union Fidelity. We sent these reports to all jurisdictions in which these companies wrote and to the NAIC offices. Ultimately, one company responded to the report; that was American Income. They did make an attempt to clean up the violations. Approximately half of them were cleaned up to our satisfaction. We were working on a response to the other half. The other three companies made no attempts to correct any of the violations that we alleged in the report.

At this time, May 1979, my employment with the Division of Insurance was terminated.

Mr. PEPPER. By action of the State insurance commissioner?

Mr. WRIGHT. The insurance commissioner fired me. It was interesting. Shortly before Commissioner Stone left Massachusetts, he said, "You know that these companies will attempt to retaliate against you if you push these studies through." I said, "Well, you said so, Commissioner, and I will take your word for it."

When I did get fired by Commissioner Stone's replacement and I asked him why I was fired, he said, "It was a management decision." He was not able to look me in the eye and tell me anything.

Mr. PEPPER. Based upon these reports, the selling of cancer insurance is forbidden?

Mr. Wright. Yes, based on these studies. Approximately 6 months afterwards, in September 1979, I believe.

Mr. Pepper. Thank you very much, Mr. Wright. We appreciate that. Mr. McCabe.

Mr. McCabe. Thank you, Mr. Chairman. I have prepared a written statement which has been submitted. I will ask that it be accepted at this time. I do have a brief summary of it, if you would like.

Mr. Pepper. Without objection, it will appear in the record.

Mr. McCabe. Thank you, Mr. Chairman.

I was an attorney who was involved in overseeing the market conduct examination of Union Fidelity. I also acted as an adviser and consultant on the other three market conduct exams. In the course of my investigation, I also had the opportunity to review Union Fidelity's activities in other jurisdictions and I also had the opportunity to review the cancer insurance industry as a whole in order to try to get some perspective on the activities of Union Fidelity and the companies we examined.

The comments I am going to make today are about Union Fidelity; however, they apply to the industry as a whole. I think, incidentally, I think a national regulation is necessary because almost all of the violations that I found of Massachusetts law would be a violation of most other jurisdictional laws. It is enforcement that is the problem.

In any event, the general standard that I employed, or review I employed, in reviewing the advertising and the marketing materials and practices of the company, required full disclosure by the company and the basic concept of fundamental fairness.

This assumes that the ultimate consumer is going to have the information on which to make an informed decision when he buys the product.

With the particular segment of the population which buys cancer insurance it is a virtual impossibility because I don't know the course of treatment of cancer and I don't know the costs of cancer and I don't know the risks associated with it.

So the consumer himself does not know the information on which to make an informed decision. The companies do virtually nothing to provide adequate information, and in fact, it was my opinion they went out of their way to avoid accurate information. The violations that I found were widespread and pervasive and they were repeated over and over again. It is the cumulative effect of these violations that is as devastating as the individual effect of the individual violations.

I have a list. I have itemized them in detail in my written summary, but I can give you a list of the violations which I found repeated over and over again and the ones that appear in the industry.

In short, these are the varieties of violations:

1. Failure to disclose material and relevant information about the risks of cancer, the costs associated with cancer and the benefits of the policy as they related to these risks and costs.
2. The policies were filled with half-truths and ambiguities that not only had a tendency and effect of deceiving and misleading the consumer, but were intended to do so.
3. Advertising emphasized and exaggerated the ugliness and the cost of cancer, but did little to relate it to the policy and included much other irrelevant information.

4. The policies and the marketing techniques promoted fear and high emotion as a sales device, whether the sales were through mass mailing or through a direct sales approach.

5. The policies and the sales agents that we reviewed preyed upon the loneliness and isolation of the elderly and the inability of the elderly consumer to find relevant information on which to base the decision.

6. They promised benefits in the policies that were literally impossible to collect. Mr. Wright has mentioned some of them. There are others that are literally impossible to collect under the terms of the policy.

Many of the benefits that were promised and were literally possible to collect were highly improbable to collect. For instance, to collect maximum ambulance benefits you had to be hospitalized 10 different times during a 36-month period. Each hospitalization had to be separated by a period of 30 days or more in order to collect the $75 reimbursement for ambulance expenses. This is representative of other benefits. It is virtually impossible that that could ever happen. The policies omitted references to limitations and exclusions throughout the policy.

Many of the policies, and this is similiar to what my brother, the assistant attorney general, said, were marketed through bogus affinity groups. The companies would develop things called the Catholic Trust or the American Sportsmans Insurance Trust. They were completely set up, operated, and run by Union Fidelity personnel. In one of the situations we had a computer programer who was the nominal chairman of one of the trusts because he happened to be a Catholic, I presume, or whatever. In any event, they gave the appearance of being endorsed and sponsored by reputable organizations such as the Catholic Church. This was not true. They used preposterous and misleading statistics in the sale of their policies.

There are many more varieties of violations which I found and I have listed them in my report. I note that the market conduct exams are included in the House report that was issued today. They speak for themselves. In any event, I would like to thank you for the opportunity to speak with you today. I would be happy to amplify any of the information I have given or answer any other questions that you may have.

Mr. PEPPER. Based upon your knowledge of the subject, do you concur in the decisions of the authorities regulating insurance in Massachusetts to prohibit the sale of cancer insurance in the State?

Mr. McCABE. Yes.

Mr. PEPPER. Well, thank you very much, Mr. McCabe.

Mr. McCABE. Thank you.

Mr. PEPPER. Have you any questions, Mr. Marks?

Mr. MARKS. Yes, if I may, Mr. Chairman. Thank you.

Mr. Wright, you left us with the impression that you were fired as a result of this investigation.

Mr. WRIGHT. I believe I was, sir.

Mr. MARKS. Beyond the fact that you were involved in the investigation, that you participated rather dramatically in it, and subsequently, after Commissioner Stone left, you were fired. What other evidence of that do you have?

Mr. WRIGHT. I have no hard evidence, sir. No one told me that I was fired because I had worked on these cancer studies.

There were two other people who were fired at the same time I was. One of them, a man named Walters Kemp, worked on the cancer studies. He was our in-house, division-of-insurance attorney on the subject. He was fired the same day I was, at the same time.

The other individual was fired for other reasons.

Mr. PEPPER. By whom were you fired, Mr. Wright?

Mr. WRIGHT. I was fired by the then and present commissioner of insurance, Michael Sabbagh.

Mr. MARKS. Thank you.

Mr. Petricoff, if I may, I notice that the State of Ohio is one of the few States that did not reply specifically to the questions that were sent out by our committee that had to do with our report. Although I am no being critical of you, I wonder if you might take the message back to your insurance commissioner that we would like, even at this late date, to see whether he can't be a bit more candid. I think Ms. Oakar mentioned that in her comment earlier. We don't see any reason why the great State of Ohio could not be a little bit more candid with us.

Mr. PETRICOFF. Thank you. I will take the message back. We have a new director of the Department of Insurance. So maybe there will be a reply forthcoming.

Mr. MARKS. Thank you, Mr. Chairman.

Mr. PEPPER. Mr. Chumbris.

Mr. CHUMBRIS. I have just one. Mr. Wright, what are you doing now?

Mr. WRIGHT. I work for the Massachusetts Horticultural Society now. I am the chief financial officer there.

Mr. CHUMBRIS. You are still working for the State?

Mr. WRIGHT. No, sir. This is not a State agency.

Mr. CHUMBRIS. Good. Now that you are not working for the State, do you have any recommendations as to how to cure this problem now that you are a private citizen?

Mr. WRIGHT. I would like to see cancer insurance banned; yes, sir. I would like to see each jurisdiction ban it. I don't think this will be done unless there is pressure brought from someplace such as this committee or the Congress.

Mr. CHUMBRIS. Mr. Chairman, thank you.

Mr. KEMP. Just a couple of points, if I might.

Approximately how many specific violations of State law did you find in the four conduct market examinations?

Mr. WRIGHT. Well, there were somewhere in the neighborhood of 300 in Union Fidelity alone. I think we had something like 20 in American Income. Washington National, I did not review, so I am not sure.

I think we must have had well over 50 in American Income. The total must be somewhere in the neighborhood of 500 specific violations of the law.

Mr. KEMP. Are these all itemized in the report?

Mr. Wright. These are itemized in great detail in the report.

Mr. Kemp. Finally, would you say that your findings are peculiar only to Massachusetts, or do you feel that the findings would have applicability to other States as well?

Mr. Wright. I am completely confident that these findings go across all the States.

Mr. Kemp. Thank you very much.

Mr. Pepper. Mr. Wright, I can't let the occasion go by without commending your patriotic action in risking your job. You were informed that you were jeopardizing your job by telling the truth and trying to make an honest investigation and the ax finally fell upon your head, showing perhaps the extensive reach and power of some of these companies.

Another man was fearful of the expense he was going to have to incur in defending himself against a law suit. That is patriotic service that I think should be commended by the Congress, and I am sure, Senator Metzenbaum would join me and both of our committees would join us in commending your courageous action in doing what you thought was the right thing.

Mr. Wright. Thank you very much for your comments, sir.

Mr. Pepper. Well, I believe that concludes our hearing.

Mr. Wright, Mr. McCabe and Mr. Petricoff, we appreciate very much your being with us here today and giving us the valuable testimony you have.

Mr. Wright. Thank you.

Mr. McCabe. Thank you.

Mr. Petricoff. Thank you.

[The prepared statements of Mr. Petricoff and Mr. McCabe follow:]

Prepared Statement of M. Howard Petricoff

Mr. Chairman, members of the joint committee, my name is M. Howard Petricoff, assistant Ohio attorney general, and I appear today on behalf of William J. Brown, attorney general of Ohio, in order to present the memoranda requested by this joint committee and to explain the circumstances under which they were issued.

Under the constitution and revised Code of the State of Ohio, the Attorney General is required to enforce State law and provide legal counsel for State government. It was in this latter role that in October of 1978, Attorney General Brown issued a memorandum to the director of administrative services concerning the cancer insurance offered to employees of the State of Ohio.

The memoranda issue was the result of an investigation initiated when the director of a regional crime laboratory called the attorney general to complain about cancer insurance salesmen soliciting State employees on State property, during working hours.

Subsequent review of the incident revealed problems far more serious than the insurance agent's technical trespass. The policy the agent was trying to sell was a cancer insurance policy marketed through a master contract between the insurance firm and the State of Ohio.

In accordance with this master policy the State assumed the administrative cost of making monthly premium deductions from State employees, which it would then turn over to the company, in exchange for lower premiums charged the group of State employees who signed up. Although this arrangement has all the trappings and most of the advantages to the insurance company of "group insurance," it lacked the basic consumer "benefit of premiums based on the actual cost of service provided the group.

Our office asked the representatives of the American Family Life Assurance Co. to submit the actual pay-out ratio on the cancer insurance policies it sold to

State of Ohio employees through the master contract. The company balked, stating that it was impossible to produce those figures. The minimum standard pay-out ratio established by the National Association of Insurance Commissioners for individual health and accident policies is 50 percent. Further, the industry standard pay-out ratio for group accident and health policies is generally around 80 percent. In fact, the general health and accident insurance offered to Ohio State employees through Blue Cross/Blue Shield is about 90 percent.

According to records on file with the Ohio Department of Insurance for 1977, American Family Life Assurance, the largest provider of the cancer coverage, only paid out 34 cents in benefits for every dollar of accident and health premium they collected in 1977. For 1978, the company-wide figure was 35 cents.

Judging from the master cancer contract for Ohio employees, reasons that the pay-out ratio for cancer insurance may be so low are the severe limitations on the payment benefits. For example, the master cancer policy for Ohio employees contained low maximum payments for various hospital treatments, surgery, and total benefits paid. In addition, even these benefits would not commence until the insured was hospitalized for cancer. This precondition of hospitalization eliminates compensation for the expense of cancer treatment conducted solely on an out-patient basis.

The fact that the cancer insurance offered State employees was a terribly one-sided bargain is only part of the reason that the attorney general terminated the master policy for employees of his office in October of 1978. What troubled the attorney general was the conflict between the payment provisions of the cancer insurance and the coordination of benefits clause in the general health and accident policies also offered State employees.

Coordination of benefits provision is a device used by many group plans to lower health care costs without jeopardizing legitimate insurance needs. To prevent the incentive to make an unfounded claim coordination of benefits provisions reduces group compensation so that the total an employee receives from all health and accident insurance does not exceed the total cost for medical services. Since the State master cancer insurance policy provided compensation only for medical expenses which were already covered by the general health and accident policy, it was possible for coordination of benefits to take place. Thus, employees who were able to collect on their cancer insurance may receive no additional benefit for the premiums paid for that cancer coverage, as the regular health insurance will reduce payment benefits by the amount paid out from the cancer insurance.

In November of 1978, the attorney general wrote the director of administrative services outlining the problems with the cancer policies offered State employees and suggesting three remedies including termination of the master cancer policies.

Thus far, the director of administrative services has taken two of the three suggestions. First, he has issued a directive barring the solicitation of insurance policies on State property during work hours. Second, the master policy between the State of Ohio and American Family Life has been terminated for the attorney general's employees, and for other State employees reformed to avoid the most direct application of coordination of benefits. The final step of terminating the master cancer insurance policies has not been taken but will be discussed again this October when the policies expire.

Thank you for this opportunity to address the joint committee, I would be happy to answer questions at this time.

Prepared Statement of Arthur J. McCabe II

Gentlemen: Thank you for the opportunity to speak with you concerning my experience, observations, and recommendations on the subject of cancer insurance and the methods employed in marketing it. My testimony is based upon my personal experience, acquired in the performance of four market conduct examinations for the Division of Insurance of the Commonwealth of Massachusetts. In July of 1978 I was retained as an outside consultant to be part of a broad-based examination team to conduct the market conduct examinations on four insurance companies marketing cancer insurance. The four companies are: Union Fidelity Life Insurance Corporation, Trevose, Pa.; American Family Life Assurance Co., Columbus, Ga.; American Income Life Insurance Co., Indianapolis, Ind.; and Washington National Insurance Co., Evanston, Ill.

I. Market conduct examination procedures

The examination team was comprised of private attorneys with particular expertise in the area of trade regulation and consumer laws; outside accountants familiar with audit procedures and insurance practices; and an outside market research firm to gather market data and prepare a statistical profile of the insurance company's activities. The team worked closely with the research and education staff and the chief examiner of the Massachusetts Division of Insurance. I was personally responsible for overseeing the market conduct examination of Union Fidelity Life Insurance Corp., and I acted in an advisory and consulting role with regard to the examinations of the other three companies. My testimony today pertains primarily to Union Fidelity, although the trade practices of Union Fidelity are fairly representative of practices of the other companies examined by the division with regard to the marketing of cancer insurance. Union Fidelity, however, is worthy of close scrutiny in that division personnel determined that the companies examined, the market conduct of Union Fidelity has been the most harmful to the public and the least defensible, at least within Massachusetts.

The examination of Union Fidelity took place from August through December of 1978 and it involved investigation and research at the company headquarters and in the marketplace. Additionally, to determine company procedures for responding to notices of marketing deficiencies, I examined the market conduct of Union Fidelity in other jurisdictions. I also examined the practices of other insurance companies in the industry to determine if Union Fidelity were unique in its marketing of cancer insurance. Based upon those examinations and the review made by the team, I determined that the marketing activities of Union Fidelity were representative of widespread marketing practices of companies selling cancer insurance.

Initially, it is important to state what this testimony is not. It is not an exercise in defense of or in support of the special market conduct examination of Union Fidelity conducted by the Massachusetts Division of Insurance. That report speaks for itself. The findings of the report are the subject of an administrative hearing being conducted by the division of insurance and are the subject of an action being contemplated by the attorney general in Massachusetts. Nor is this testimony intended to single out Union Fidelity or any other individual insurance company. If the practices of the companies stand out, they do so on their own. This testimony is simply a statement of facts and observations developed and discovered by the examination team in the performance of our work.

In conducting the examinations we were directed to perform a full, complete, and objective study of the market conduct of Union Fidelity and the other companies and to review the various policy forms and procedures utilized by the companies. To insure objectivity, the division employed outside consultants of complementary expertise. Consequently, findings in our examination are all buttressed by at least two areas of expertise. For instance, findings of deceptive and misleading advertising were buttressed by the findings of the market research analysts that policyholders did not understand the coverage they had purchased. Findings that limitations and exclusions are too restrictive were buttressed by findings of the accountants that loss ratios are low. Thus, there was no segment of our report which was not supported by empirical and corroborative evidence. The main point is that we were not intended to be, nor were we, judge, jury, and implementer. We simply conducted an investigation and reported our findings. It is the job of the regulators and of subcommittees like yours to determine what, if any, action is warranted.

I have provided this background information to you so that you would have some foundation and perspective on which to gauge the significance of my testimony. It is also useful to set forth the legal standard of review which is applicable to marketing practices in Massachusetts and most States.

II. Legal standard of review

As you know, most of the laws applicable to sales, advertising, and promotional material are based upon fundamental concepts of fairness and full disclosure. In summary, advertising capable of being interpreted in a misleading way should be construed against the advertiser. One should look not only to the literal meaning of words but also to all that is reasonably implied. It is also necessary to view advertising as it would appear to the general public, and particularly that segment of the population to which the advertising is directed. This aspect is particularly critical with regard to cancer insurance because it is primarily marketed to the elderly, many of whom are not conversant with health and insurance needs.

It is a fact of the marketplace that many who make purchases do not or cannot stop to analyze fully the advertising claims; and all too often decisions are governed by appearances. The elderly are particularly susceptible to deceptive and misleading advertising because they have least access to full information. Certainly in order to evaluate the completeness and fairness of advertising and promotional materials, it is necessary to know all that is relevant to the subject matter of the advertising, including much information which is omitted from the actual advertisements. In the case of cancer insurance, it is necessary to acquire and analyze extensive information concerning the costs of medical treatment, the courses of treatment, the development of the various diseases, and the health care resources available to the general public. This is a task which is virtually impossible for the overwhelming majority of the general public. The enormity of this task underscores the need for full and fair disclosure in company advertising. It is apparent that, as between the insurance company and the consumer, only the company has a realistic opportunity and the economic and reference resources available to perform such a task.

III. Who buys cancer insurance?

A. UNION FIDELITY MASS MAILING APPROACH

According to the examination team survey results, the single most significant characteristic of Union Fidelity policyholders in Massachusetts is that they are elderly. As a consequence of their age, they exhibit a number of other associated demographics, such as low income and a high number of widows.

UNION FIDELITY POLICYHOLDER SURVEY RESULTS

[In percent]

	Total	Men	Women
Age:			
Up to 59 yr	10	13	8
60 to 69 yr	24	24	26
70 to 79 yr	45	43	51
80 yr and over	14	17	12
Income:			
Under $15,000	66	63	74
Over $15,000	19	23	14

Forty-seven percent of women respondents were widows, and three-fourths of the widows lived alone. One major indicator of the extreme age of the sample was the very large number of respondents who broke off in the middle of the interview. General experience and indeed our experience with the other companies in this study, which had a younger age sample, shows this to be characteristic of the elderly.

Medicare and Blue Cross

More than three-fourths of the entire sample was covered by medicare. Given the high average age this is not surprising, but it is significant from the standpoint of coordination of benefits. Similarly, despite their age, two-thirds of the sample were covered by Blue Cross/Blue Shield. Only about 5 percent of the entire sample had neither Medicare nor Blue Cross/Blue Shield coverage.

Policy ownership

Still another characteristic related to the elderly was the large number of respondents who did not know that they had any cancer policy or indeed any policy with Union Fidelity. Again, this lack of recall of policy ownership was much less true among policyholders of the other two companies studied in this project.

About two-thirds of the total sample knew they had a policy. Only about three-fifths of those who Union Fidelity says have a cancer policy recall having the policy. This drops to only half of those 80 years of age or older.

Agents and brochures

The data substantiates that Union Fidelity policies are overwhelmingly purchased through the mail. Some of the other companies emphasized direct agent sales. The problems of agent conduct are discussed below.

Over 80 percent of those who know they have a cancer policy recall having seen or read a brochure. A majority of the entire sample says that they have read the entire brochure. Respondents gave a wide variety of answers to questions about what they specifically remembered from reading the brochure. The two most common answers, which between them were given by about half of all respondents, touched on the costs and incidence of cancer.

Factors motivating choice of policy

The primary motivations cited by respondents for choosing the Union Fidelity policy was that it was the only cancer policy they had ever heard of or that it was made conveniently available through the mail. The underlying motivations for buying a cancer policy at all were related to fear of the disease itself or to its cost and widespread incidence among the population.

Given this motivation of fear of cost coupled with the availability of insurance, the average respondent presumably should be concerned with the actual benefits the policy would pay if a high cost cancer attack should occur. Most respondents do not understand the amount of benefits of the Union Fidelity policy. When asked what part the policy would pay of a total hospital/doctor bill of $20,000, only about 5 percent of those who even knew they had cancer policies estimated that the insurance would pay less then half this amount, which is an accurate guess. One-quarter said they would receive all of the $20,000, and more than half admitted that they did not know. Given the normal payout of about 35 percent, it is clear that most respondents either grossly overestimated or had no idea what their policy benefits really are.

Respondents showed a similar lack of knowledge of specific policy conditions. For example, more than half of policyholders did not know if there was a time limit on benefits and the balance split evenly between "no time limit" and "yes, a time limit."

In conclusion, the market conduct survey reported that Union Fidelity sells cancer insurance almost exclusively to elderly people through the mail by emphasizing the costs and financial burdens of cancer. This sales approach results in policyholders who have little knowledge of the actual benefits provided by Union Fidelity and who also have overlapping coverage with Blue Cross/Blue Shield or Medicare.

This profile would appear to be typical of those companies which utilize a direct mail approach. In the case of Union Fidelity, were told by its marketing director that the company was now going to embark on a major effort to increase sales through agents without cutting back on its mailing program.

B. AMERICAN FAMILY—DIRECT SALES APPROACH

American Family is respresentative of companies selling by direct sales. According to the field study prepared for the division, American Family sells policies in two distinct ways: door-to-door and through employers at the place of employment. In either case, however, American Family uses an agent. Altogether 8 out of 10 respondents knew they owned an American Family cancer or intensive care policy and of these, more than 90 percent say they bought through an agent.

Purchasers on the job

Roughly half of those who know they own a cancer policy bought it at their place of employment. The great majority of these people think the policy is endorsed by their employer, but conversely ony one in five thinks it is a part of their benefits package. Finally, seven out of eight pay for the policy by payroll deductions. Thus, respondents appear to have a fair understanding of the relationship of American Family to their employers. It is certainly reasonable to think that if an employer first allows an agent to sell at the job location and then deducts the premiums from payrolls, that the employer is "endorsing" the policy: and most respondents know that they, and not the employer, are paying for the policy. The legality of such an implied endorsement is questionable, especially in the many cases where the employer is a unit of local government. For instance, a very large portion of the sample worked in some way for a municipal government in Massachusetts.

Purchasers at home

The median age of those individuals who purchased a policy in their homes is close to 70.

CANCER POLICY

[In percent]

	Total	Bought at work	Bought at home
Age:			
18 to 49 yr	37	59	10
50 to 59 yr	16	23	9
60 to 69 yr	27	16	40
70 yr and over	20	2	4

Since virtually everyone in the sample over 70 is covered by medicare and three-fourths have Blue Cross-Blue Shield coverage as well, it is probable that there is a significant problem of coordination of benefits.

It should also be noted that the refusal rate on this study was quite high. For example, 21 people were not included in the tabular results because they either terminated in the middle of the interview or refused to answer a preponderance of the questions. For each of these we have the respondent's age from the records supplied by American Family. Almost two-thirds of all these respondents were over 60, compared to fewer than half of those actually interviewed.

Agents and brochures

Whether bought at the job or at home, the respondents said that they talked to an agent. Only 1 in 15 knew the agent before and most have never seen the agent again. Apparently, American Family agents sell the policy and go on to the next sale.

The agent does use a sales brochure. Three out of four respondents have seen or read a brochure. By far, the single largest area of recall as to what the brochure said dealt with the increasing cost of cancer.

Factors motivating buying a policy

The respondents in this sample say they bought a cancer policy because of fear of the disease itself or of its cost and because of the widespread incidence of cancer. They chose an American Family policy because it was the only policy they had heard of, because it was recommended by their employer, or because of the influence of the agent.

At least some of this information about incidence of cancer had come from the agent. Three-fourths of those who bought through an agent said he had mentioned that "1 out of 4 Americans will eventually get cancer," while almost as many said he had mentioned that "breast cancer strikes more women than any other form of cancer."

Given the motivation of fear of cost coupled with availability, one would presume that the average respondent would be concerned with the actual benefis the policy would pay if a high cost cancer attack should occur. However, most respondents do not even claim to understand the potential benefits of the policy. Two-thirds of those who claim to have cancer policies do not know what fraction of either a $20,000 or $2,000 cancer bill would be paid on the average. Of those who do think they know, substantial majorities say all of the bill would be paid.

Majorities of respondents also do not know whether the policy pays each of five specific benefits.

In conclusion, American Family sells cancer policies in two ways: by door-to-door sales to predominantly older people who are in their 60's and early 70's, and to younger people at their place of employment.

In both cases, their policyholders are not particularly well informed as to the benefits of the policies, and in many cases they have overlapping coverage with Blue Cross-Blue Shield and/or medicare.

American Family's agents are clearly more interested in presenting the horrors and catastrophic costs, real or imagined, of cancer than they are in describing the likely real benefits of the policies they sell.

IV. Cancer insurance advertising and marketing practices

A review of some of the advertising material which is mailed to prospective policyholders is illustrative of the marketing practices of Union Fidelity and the other companies. In one of the brochures reviewed, there were in excess of 90 apparent violations of Massachusetts laws. In another brochure for a rider to a cancer policy sold by Union Fidelity, in excess of 120 apparent violations were cited. The brochures reviewed were representative of other advertising material used by Union Fidelity; and Union Fidelity, in turn, was fairly representative of other companies marketing cancer insurance. The apparent violations cited were not exhaustive of all violations related to the marketing of cancer insurance.

Furthermore, since it is the overall impression the advertising makes on the general public which is of greatest concern, the repetitive and cumulative nature of these violations is alarming. In summary, the brochures failed to include sufficient material and relevant information to permit the consumer to make a meaningful and informed decision concerning the adequacy and appropriateness of the insurance policy promoted. The information omitted includes, but is not limited to: average individual costs of cancer treatment, courses of treatment of cancer, company loss ratios (benefits paid per premiums received), and the relationship of cancer insurance to other insurance available to the consumer. As a result, the reviewed advertising was not sufficiently clear and complete to avoid deception or the capacity or tendency to mislead or deceive the consumer.

The brochures reviewed contained numerous half-truths or ambiguous statements which contribute to the capacity or tendency of the materials to mislead or deceive. In some cases, because of the time limit and the benefit structure of the policy, it is literally impossible for the policyholder to collect benefits as advertised. In other cases, because of the usual course of cancer treatment and general hospital practices, it is highly improbable, but not literally impossible, that full benefits will be paid. In any case, the sale of the subject policies is unconscionable when viewed by accepted legal standards.

The findings with regard to the market conduct of American Family Life Assurance Co. and American Income Insurance Co. in the marketing of cancer insurance are no less conclusive or offensive.

In an internal report of the commissioner of insurance based upon the market conduct examinations it was stated succinctly: "The cases against the three cancer insurers are remarkable both for the vast amount of effort and resources which have gone into them and for the high quality of the results. The three market conduct reports are thorough and clearly sound. * * * It is rare for an enforcement case * * * to be so lopsided that the desired result is virtually assured. It is also unusual for the injury to the public to be so clear that the need for a remedy is unequivocal."

Based upon the reports, on July 19, 1979 the Commissioner of Insurance in Massachusetts docketed adjudicatory proceedings and issued orders to show cause against Union Fidelity, American Family, and American Income.

The substantive allegations made in the order to show cause are listed in exhibits A, B and C attached hereto and made a part of this letter.

[Exhibits A, B, and C follow the prepared statement.]

Even a cursory review of the allegations listed in the exhibits reveals many similarities in the advertising and marketing practices employed in the promotion of cancer insurance. This indicates that the practices are pervasive in the industry and that a far-reaching response is the only hope to prevent abuses in the future. It should be noted, however, that all of the allegations listed in the exhibits are violations of existing laws. Therefore, new regulations alone are not sufficient. Furthermore, each of the companies cited in Massachusetts had previously been cited for substantially similar violations in numerous other States. Thus, if additional enforcement and regulation is the answer, it must be done at the Federal level in order to insure uniformity.

As stated in a study of cancer insurance prepared for the Massachusetts Division of Insurance, "combining exploitative sales practices with a paucity of benefits, cancer coverage embodies the worst possible extremes of health insurance marketing and product design."

V. CONCLUSIONS AND RECOMMENDATIONS

Given the widespread and obvious nature of the abuses, prompt action is required. There are few basic remedial measures which can be utilized individually or in combination:

1. Strict enforcement of existing laws and regulations;
2. Expansion and refinement of regulatory and enforcement procedures including the expansion of a private cause of action and class action remedies for aggrieved consumers;
3. Industry self-regulation;
4. Banning cancer insurance;
5. Requiring cancer insurance to be sold only in conjunction with broad-scope health insurance.

Strict enforcement of existing laws and regulations is at best a temporary solution. At present there is no Federal standard and therefore there is no uniformity among the States. This not only leaves the consumers in a precarious situation depending upon where he or she happens to reside, but it promotes inefficiency within the insurance companies because it requires unnecessary bureaucracy. It also puts an unnecessary regulatory burden on already overworked State regulators. A Federal regulatory standard would provide the desired uniformity; and, if it were accompanied by a private right of action, the burden of enforcement would be spread more evenly throughout society.

Industry self-regulation and industry participation in the development of a Federal standard is desired. The stronger, more reputable insurance companies are in an excellent position to promote higher standards of industry market conduct and, in the process, to better serve the consumer. One method of encouraging self-regulation would be to require that cancer insurance be sold only in conjunction with broad-based health insurance coverage. This alternative would also facilitate comparison of coverages by consumers.

The first and last approach is an outright ban on cancer insurance as it is now marketed. Some States have already done this. An immediate and complete ban is probably desirable to prevent further abuse of the consumer. However, in view of the success of the sale of these policies to date, there is clearly a desire on the part of the consumer to have some form of catastrophic illness coverage. Consequently, the product is likely to reappear in some form thereby requiring the implementation of one or more of the other remedial measures mentioned above.

Once again, I want to thank you for the opportunity to speak to you today and to make this presentation. I recognize that it is unlikely that a single subcommittee hearing will result in the sweeping policy and enforcement changes which I personally believe are warranted. However, I am encouraged by your interest and urge you to continue your work until such changes are forthcoming.

If you require any additional information or have any questions, please contact me.

Attachments.

EXHIBIT A

UNION FIDELITY LIFE INSURANCE CORPORATION

1. Advertisements include superfluous information which has the effect of concentrating the reader's attention on cancer itself and away from the benefits of the policy advertised, thereby inviting the purchase of health insurance for emotional rather than functional reasons.

2. Advertisements exaggerate the incidence of cancer so as to invite the purchase of health insurance for emotional rather than functional reasons, in at least the following ways:

   a. Advertisements present cancer incidence statistics without reference to an applicable time period.

   b. The cancer incidence statistics presented are, in fact, for a lifetime and are approximately 70 times higher than those for a year. These lifetime statistics are used even though the policy advertised is issued for only one year and many persons do not actually renew it throughout their lives.

   c. Cancer is said to strike "2 out of 3 families." Use of this statistic is inappropriate since the family plan of the policy being advertised covers children only up to age 21 or 23 and cancer is comparatively rare among young persons in such families.

   d. Cancer incidence statistics are presented as valid for any prospective purchaser without any mention of their great variability by age, community and personal habits.

   e. Cancer incidence statistics of the American Cancer Society are presented as facts, even though they are only estimates and the Society cautions that they "are offered as a rough guide and should not be regarded as definitive."

   f. Cancer incidence statistics are presented on a per "street" basis, even though this is not statistically credible.

   g. Cancer mortality statistics are presented even though the policy advertised offers no life insurance protection.

3. Advertisements exaggerate the cost of cancer so as to invite the purchase of health insurance for emotional rather than functional reasons, in at least the following ways:

   a. Advertisements present statistics regarding the total cost of cancer in the U.S. (e.g., $3 billion a year), even though this aggregate figure has no relation to the medical costs not covered by the policy advertised.

b. Advertisements describe costs using imprecise words such as "smothering," "overwhelming," and "crushing," and sentences such as "The expenses are impossible to meet. It puts you so far in debt you can't even look ahead."

c. Advertisements imply that all cancers are expensive to treat, even though the cost varies greatly by type of cancer and time of diagnosis.

d. Advertisements imply that financial ruin is likely without cancer insurance by stating (falsely) that one has only two choices — either ignore the threat of cancer, or seek protection by applying for Union Fidelity's cancer policy.

e. Advertisements omit any reference to the ability of one's existing (non-cancer) health insurance to cover cancer costs.

4. Advertisements tend to mislead purchasers or prospective purchasers as to the nature or extent of the policy benefits payable or losses covered, in at least the following ways:

a. Advertisements prominently display a total maximum benefit limit payable under the policy being advertised (e.g., $150,000), which is very unlikely to be obtained by any claimant.

b. Advertisements state a total maximum benefit limit without stating (i) over 90% of the total consists of benefits for continuous hospital stays in excess of 90 days, (ii) stays of this length are extremely rare, and (iii) to reach the maximum, one would have to be hospitalized continuously for approximately 18 months.

c. Advertisements describe the "extended hospital benefits" for continuous hospital stays of over 90 days without mentioning that stays of this length are extremely rare.

d. Advertisements give more prominence to the maximum benefits payable per day for continuous hospital stays in excess of 90 days (e.g., $333.33) than to the benefits for shorter days (e.g., $120.00), even though shorter stays are much more common.

e. Advertisements imply that the benefits being offered will supplement any other insurance policy (e.g., "Provides benefits for Cancer treatment in addition to any Group Insurance Plan"), even though the cancer benefits being offered may be a substitute for (i.e. be in lieu of) the benefits of the other insurance policy if that policy contains a coordination-of-benefits clause.

f. Advertisements specify that cancer has higher costs than other illnesses, but the items listed (drugs, physician services, nursing care, sick-room equipment) are covered only in part and only under particular circumstances.

5. Advertisements do not fairly and accurately describe the negative features of the policy's limitations, exceptions and reductions, in at least the following ways:

   a. Advertisements characterize the maximum limit of the policy being advertised as a "lifetime" maximum even though the policy does not pay for any benefits after three years from the date of cancer diagnosis.

   b. Advertisements minimize the limitations, exceptions, and reductions of the policy being advertised by not presenting them prominently.

   c. Advertisements omit exceptions, reductions and limitations of the policy being advertised, including (i) the policy covers cancer only if it is positively diagnosed by a pathologist — cancer diagnosed clinically is excluded, (ii) the policy pays only for loss resulting directly from the treatment of cancer and does not cover any diagnostic services, (iii) the policy does not cover any treatment services which are received more than 10 days prior to the date of diagnosis (43 days in the event the diagnosis can only be made post-mortem), and (iv) the policy does not cover any other disease or sickness or incapacity even though such condition may have been complicated, aggravated or directly affected by cancer or cancer treatment.

6. Advertisements also tend to mislead purchasers or prospective purchasers in at least the following ways:

   a. Advertisements contain endorsements of Union Fidelity and its policies without disclosing that the person making the endorsement is affiliated with Union Fidelity.

   b. Advertisements imply that an independent group insurance trust selected Union Fidelity and its cancer "plan" after a careful search for the best insurer and coverage, even though the administrator of the trust which "selected" Union Fidelity coverage was either Union Fidelity or one of its affiliated companies.

   c. Advertisements state that prospective insureds will not have to pay "top dollar" for individual coverage because they are eligible for "low group rates" under the "$200,000 Cancer Plan," even though the rates are only 10 cents a month (approximately 1%) below individual rates for the same coverage.

d. Advertisements imply that the recipient has had his eligibility for insurance individually determined in advance, even though the advertisements are directed to all persons whose names appear on a mailing list.

7. Union Fidelity sells cancer insurance coverage through group insurance trusts (e.g., United Catholic Group Insurance Trust) under which the power to select the insurer of the trust resides in Union Fidelity or one of its affiliated companies.

EXHIBIT B

AMERICAN FAMILY LIFE ASSURANCE COMPANY

1. Advertisements exaggerate the incidence of cancer so as to invite the purchase of health insurance for emotional rather than functional reasons, in at least the following ways:

   a. Lifetime cancer incidence statistics are advertised, which are approximately 70 times higher than those for a year. These lifetime statistics are used even though the policy advertised is issued for only one year and most persons do not actually renew it throughout their lives.

   b. Cancer is said to strike "2 of every 3 FAMILIES" (with an accompanying picture of two adults and two small children). Use of this statistic and picture is inappropriate because the family plan of the policy advertised covers children only up to age 21 or 23 and cancer is comparatively rare among young persons in such families.

   c. Statistics on cancer incidence are presented as valid for any prospective purchaser without any mention of its great variability by age, community and personal habits.

   d. Cancer incidence statistics of the American Cancer Society are presented as "facts," even though they are only estimates and the Society cautions that they "are offered as a rough guide and should not be regarded as definitive."

   e. Isolated statistics purporting to show great increases in male lung cancer imply that cancer incidence is rising when in fact the American Cancer Society notes that the overall incidence of cancer has decreased slightly in the past 25 years. For example: "increased 2,000% since 1903," "increased 1,500% since 1930," "increased over 125% in 25 years."

2. Advertisements exaggerate the cost of cancer so as to invite the purchase of health insurance for emotional rather than functional reasons, in at least the following ways:

   a. Advertisements present statistics regarding the total cost of cancer in the U.S., even though aggregate figures have no relation to the medical costs any given individual might expect to incur, sometimes include non-medical costs, and include costs not covered by the policy advertised. For example, such statistics as "$3 billion" in 1972 and "$18.9 Billion in the United States this year" are used in the advertisements.

b. Advertisements state that cancer is probably the most expensive disease, implying that all cancers are very expensive, even though the cost varies greatly by type of cancer and time of diagnosis.

c. Many advertisements omit any reference to the ability of one's existing (non-cancer) health insurance to cover cancer costs.

d. Advertisements state that cancer costs have been rising, implying they will continue to do so, causing a special need for that cancer coverage, even though (i) the advertised American Family policy pays fixed amounts that do not rise over time, (ii) costs of other diseases and all health care have also risen, and (iii) benefits available under the prospective purchaser's other policies have also increased, reducing any need for cancer coverage.

3. Advertisements give disproportionate emphasis to cancer, its incidence and cost, rather than emphasizing the benefits of the policy advertised. This frightens and confuses purchasers and prospective purchasers with irrelevant information, distracts them from relevant comparisons, creates a marketing atmosphere conducive to deception and invites the purchase of health insurance for emotional rather than functional reasons, in at least the following ways:

   a. Cancer mortality statistics are presented even though the policy advertised offers no life insurance protection.

   b. Advertisements give disproportionate space and emphasis to cancer itself rather than the benefits of the policy advertised.

   c. Advertisements presented orally by agents mention only cancer, not insurance, until the agent is "in the door" and well into his presentation, even if a customer directly asks "Is it insurance?"

   d. Advertisements include superfluous information about cancer.

4. Advertisements tend to mislead purchasers or prospective purchasers as to the nature or extent of the policy benefits payable or loss covered, in at least the following ways:

   a. Advertisements prominently describe the "extended benefits" for hospital stays of over 90 consecutive days without mentioning that stays of this length are extremely rare.

b. Advertisements give more prominence to the maximum benefit payable for hospital stays in excess of 90 consecutive days (e.g., 100% of charges up to $5,000 per month) than to the benefit for shorter stays (e.g., $50 daily for the first seven days; $30 per day thereafter) even though shorter stays are much more common.

c. Advertisements imply that payments to be made under the advertised policy will supplement (i.e. be in addition to) payments by any other insurance policy, even though the cancer benefits being offered may be a substitute for (i.e. in lieu of) the benefits of the other insurance policy if the latter contains a coordination-of-benefits clause.

d. Advertisements represent that the policy advertised is designed to "fill the gap" left by other insurance, when in fact the policy is in no way tailored to other insurance plans, and a policy may be bought regardless of a purchaser's other insurance.

e. Advertisements imply that the advertised policy alone can prevent bankruptcy, even though American Family knows that its policies are supplemental and are designed at best to pay 50% of cancer costs; and even though the policy, on average, pays 30% or less of cancer costs.

f. Advertisements state that the advertised policy provides "extra money," "cash in your pocket," or "extra cash" to beneficiaries.

g. Advertisements state that extended benefits pay 100% of hospital charges up to a monthly limit when in fact payments are limited on a daily pro rata basis, relating to the number of days of confinement, resulting in payments which are below average hospital charges.

5. Advertisements do not fairly and accurately describe the negative features of the policy's limitations, exceptions and reductions in at least the following ways:

a. Advertisements present descriptions of the waiting period in a positive manner, even though it is a major exception to the policy advertised. For example: "you are covered after [90] days participation in the plan."

b. Advertisements minimize the limitations, exceptions and reductions of the policy being advertised by not presenting them prominently.

c. Advertisements omit exceptions, reductions and limitations of the policy being advertised. Matters omitted include the following:

   (i) the policy covers cancer only if it is positively diagnosed by a pathologist, so that cancer diagnosed clinically is excluded;

   (ii) the policy does not cover any treatment received more than 10 days prior to the date of diagnosis (45 days in the event the diagnosis can only be made post-mortem); and

   (iii) in covering only "definitive cancer treatment" costs, the policy excludes certain substantial costs incurred in caring for individuals with cancer, costs which a reasonable person would expect to be covered, especially under a policy called the "Cancer Care" plan.

   Excluded coverages comprise at least all costs of:

   (i) making a diagnosis;

   (ii) treating conditions caused by or aggravated by cancer treatment;

   (iii) rehabilitation; and

   (iv) follow-up check-ups.

6. Advertisements also tend to mislead purchasers or prospective purchasers by disparaging their existing insurance, however meritorious it may be.

EXHIBIT C

AMERICAN INCOME LIFE INSURANCE COMPANY

1. Advertisements include superfluous information which has the effect of concentrating the reader's attention on cancer itself and away from the benefits of the policy advertised, thereby inviting the purchase of health insurance for emotional rather than functional reasons.

2. Advertisements exaggerate the incidence of cancer so as to invite the purchase of health insurance for emotional rather than functional reasons, in at least the following ways:

   a. Advertisements present cancer incidence statistics without reference to an applicable time period.

   b. The cancer incidence statistics presented are, in fact, for a lifetime and are approximately 70 times higher than those for a year. These lifetime statistics are used even though the policy advertised is issued for only one year and many persons do not actually renew it throughout their lives.

   c. Cancer is said to strike two out of three families. Use of this statistic is inappropriate since the family plan of the policy being advertised covers children only up to age 18 and cancer is comparatively rare among young persons in such families.

   d. Cancer incidence statistics are presented as valid for any prospective purchaser without any mention of their great variability by age, community and personal habits.

   e. Cancer incidence statistics of the American Cancer Society are presented as facts, even though they are only estimates and the Society cautions that they "are offered as a rough guide and should not be regarded as definitive."

   f. Cancer mortality statistics are presented even though the policy advertised offers no life insurance protection.

3. Advertisements exaggerate the cost of cancer so as to invite the purchase of health insurance for emotional rather than functional reasons, in at least the following ways:

   a. Advertisements present unattributed statistics regarding the cost of treating cancer which exceed any reasonable estimate of those costs and include costs not covered by the policy advertised.

b. Advertisements describe costs using imprecise words such as "staggering," "astronomical," and "sky-rocketing," and sentences such as ". . .It's a financial disaster," "It always wipes out all the savings and leaves the family deep in debt; on top of that, if the afflicted person lives, he usually is unable to work and earn a living, and the situation becomes even more tragic."

c. Advertisements imply that all cancers are expensive to treat, even though the cost varies greatly by type of cancer and time of diagnosis.

d. Advertisements denigrate the ability of one's existing (non-cancer) health insurance to cover cancer costs.

4. Advertisements tend to mislead purchasers or prospective purchasers as to the nature or extent of the policy benefits payable, losses covered or premium payable, in at least the following ways:

a. Advertisements prominently display maximum benefit limits payable under the policy being advertised, which are very unlikely to be obtained by any claimant.

b. Advertisements state a total maximum benefit limit without stating that:

(i) to reach the maximum, one would have to be hospitalized for approximately 700 days and undergo 10 surgical operations, and

(ii) treatment of this length is extremely rare.

c. Advertisements describe the "extended benefits" for continuous hospital stays of over 90 days without mentioning that stays of this length are extremely rare.

d. Advertisements state that these "extended benefits" are payable on a monthly basis when, in fact, the amount payable is based on a daily pro rata basis relating to the number of days of confinement.

e. Advertisements give more prominence to the maximum benefits payable for continuous hospital stays in excess of 90 days (e.g., $3,000 per month) than to the benefits for shorter stays (e.g., $30 a day), even though shorter stays are much more common.

f. Advertisements present the range of payments that will be made for operations listed in the advertised policy's schedule of operations, but do not disclose the (considerably lower) maximum fee that will be paid for any unlisted operation.

g. Advertisements describe the advertised policy's transportation benefits (e.g., the policy provides money for transportation to out-of-state cancer treatment centers), without disclosing that the policy will pay for transportation only if:

(i) the type of treatment sought cannot be obtained locally;

(ii) no closer hospital provides the same treatment;

(iii) the treatment is ordered by the attending physician; and

(iv) travel is by air or rail.

h. Advertisements state that each valid claim will be increased by an additional 10%, even though this benefit is not in the policy advertised.

i. Advertisements describe premium amounts on a per day or per week basis even though actual payments are made monthly.

j. Advertisements misleadingly portray the policy being advertised as low in cost and high in benefits. This is done by minimizing the premiums (e.g., presenting them on a weekly basis) while, at the same time, exaggerating the benefits (e.g., listing the amounts obtainable if all members of a family were to collect the maximum benefits for all the risks insured against, even though some of the risks are mutually exclusive).

k. Advertisements imply that the benefits being offered will supplement any other insurance policy (e.g., "Pays full benefits regardless of other insurance"), even though the cancer benefits being offered may be a substitute for (i.e. be in lieu of) the benefits of the other insurance policy if the other policy contains a coordination-of-benefits clause.

5. Advertisements do not fairly and accurately describe the negative features of the policy's limitations, exceptions and reductions, in at least the following ways:

a. Advertisements minimize the limitations, exceptions and reductions of the policy being advertised by not presenting them prominently.

b. Advertisements falsely state that the policy being advertised is subject to "only" two limitations.

c. Advertisements omit exceptions, reductions and limitations of the policy being advertised. Matters omitted include the following:

   (i) the policy covers cancer only if it is positively diagnosed by a pathologist — cancer diagnosed clinically is excluded;

   (ii) the policy does not cover any other disease or sickness or incapacity even though such condition may have been complicated, aggravated or directly or indirectly affected or caused by cancer or cancer treatment;

   (iii) the policy pays only for loss resulting directly from the treatment of cancer and does not cover any diagnostic services;

   (iv) the policy does not cover any treatment services which are received more than 10 days prior to the date of diagnosis (45 days in the event the diagnosis can only be made post-mortem); and

   (v) the policy does not cover any treatment services which are received more than three years after the date of diagnosis.

d. Advertisements describe the 120-day waiting period of the policy being advertised in a positive manner, implying that it is a benefit.

e. Advertisements compare the waiting period of the policy being advertised to that contained in "any policy that pays for any type of medical treatment," even though the cancer policy waiting period is far more restrictive.

f. Advertisements state that the rationale for the waiting period is to protect policyholders and the company from people buying a policy knowing they already have cancer, even though this is the rationale for a pre-existing condition exception and even though the waiting period would also apply to persons who did not know they had cancer when they bought the policy.

g. Advertisements characterize the maximum limits of the policy being advertised as "lifetime" maximums even though the policy does not pay any benefits after three years from the date of cancer diagnosis.

6. Advertisements also tend to misleed purchasers or prospective purchasers in at least the following ways:

    a. Advertisements falsely imply that American Income's insurance benefits will integrate with one's existing insurance in order to provide a "full circle of protection."

    b. Advertisements state that the prospective purchaser must "make a decision this evening" since "it's just impossible" for the agent to return later, even though agents are instructed at sales meetings to make repeat calls when necessary.

    c. Advertisements directly and indirectly disparage insurers who are not fully unionized like American Income.

7. American Income trains its agents to state that life insurance and cancer insurance must be purchased as a "package" — the life insurance may not be purchased separately. If this statement reflects American Income's actual sales practices, then the "tying" together of the two policies is illegal. If instead the two policies can actually be purchased separately, then the statement constitutes false advertising.

Mr. Pepper. Well, again, we want to thank Senator Metzenbaum and his committee.

The hearing is adjourned, subject to the call of the Chair.

[Whereupon, at 1:04 p.m., the hearing was adjourned, subject to the call of the Chair.]

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APPENDIX

Letters From Claude Pepper

CLAUDE PEPPER, FLA.
CHAIRMAN

EDWARD R. ROYBAL, CALIF.
MARIO BIAGGI, N.Y.
IKE F. ANDREWS, N.C.
JOHN L. BURTON, CALIF.
DON BONKER, WASH.
THOMAS J. DOWNEY, N.Y.
JAMES J. FLORIO, N.J.
HAROLD E. FORD, TENN.
WILLIAM J. HUGHES, N.J.
MARILYN LLOYD BOUQUARD, TENN.
JIM SANTINI, NEV.
ROBERT F. DRINAN, MASS.
DAVID W. EVANS, IND.
MARTY RUSSO, ILL.
STANLEY N. LUNDINE, N.Y.
MARY ROSE OAKAR, OHIO
ELIZABETH HOLTZMAN, N.Y.
JIM LLOYD, CALIF.
THOMAS A. LUKEN, OHIO
WES WATKINS, OKLA.
LAMAR GUDGER, N.C.
GERALDINE A. FERRARO, N.Y.
BEVERLY B. BYRON, MD.
WILLIAM R. RATCHFORD, CONN.
DAN MICA, FLA.
EDWARD J. STACK, FLA.
HENRY A. WAXMAN, CALIF.
MIKE SYNAR, OKLA.
EUGENE V. ATKINSON, PA.

U.S. House of Representatives
Select Committee on Aging
Washington, D.C. 20515
TELEPHONE (202) 225-9375

CHARLES E. GRASSLEY, IOWA
RANKING MINORITY MEMBER

WILLIAM C. WAMPLER, VA.
JOHN PAUL HAMMERSCHMIDT, ARK.
JAMES ABDNOR, S. DAK.
MATTHEW J. RINALDO, N.J.
MARC L. MARKS, PA.
RALPH S. REGULA, OHIO
ROBERT K. DORNAN, CALIF.
HAROLD C. HOLLENBECK, N.J.
S. WILLIAM GREEN, N.Y.
ROBERT (BOB) WHITTAKER, KANS.
NORMAN D. SHUMWAY, CALIF.
LARRY J. HOPKINS, KY.
OLYMPIA J. SNOWE, MAINE
DANIEL E. LUNGREN, CALIF.

CHARLES H. EDWARDS III
CHIEF OF STAFF

YOSEF J. RIEMER
DEPUTY CHIEF OF STAFF

VAL J. HALAMANDARIS
SENIOR COUNSEL AND
DIRECTOR OF OVERSIGHT

JAMES A. BRENNAN
ASST. TO THE CHAIRMAN

WALTER A. GUNTHARP, PH. D.
MINORITY STAFF DIRECTOR

April 17, 1980

Mr. John O. Marsh, Jr., Esquire
Mays, Valentine, Davenport & Moore
Suite 1200
1101 Connecticut Avenue, N.W.
Washington, D.C. 20036

Dear Jack:

Your recent inquiry on behalf of the Home Beneficial Life Insurance Company has been received. You were correct when you suggested that our cancer insurance report confuses Home Beneficial with a firm of similar name which is in the business of selling this kind of insurance.

We regret the error. I have written to Senator Howard Metzenbaum to make sure that a correction appears in the March 20 hearing record. Second, I have written a note of apology to the Company President and authorized him to release it to the news media. Finally, we will make sure a correcting note is sent out with our remaining supply.

I hope this is satisfactory to you and to the company.

With kindest regards, and

Believe me,

Always sincerely,

Claude Pepper
Chairman

CP:vhs

Mays, Valentine, Davenport & Moore
Suite 1200
1101 Connecticut Avenue, N.W.
Washington, D.C. 20036
Telephone (202) 296-8560

Richmond, Va. Office
F & M Center
P. O. Box 1122 23208
Telephone (804) 644-6011

File No.

March 24, 1980

The Honorable Claude D. Pepper
Chairman
Select Committee on Aging
House of Representatives
Washington, D. C. 20515

Dear Claude:

The purpose of my writing is to enlist your assistance to remedy an error which appears on page 12 of the Report by the Select Committee on Aging entitled "Cancer Insurance: Exploiting Fear For Profit (An Examination of Dread Disease Insurance)."

As you are aware, I am a member of a Richmond law firm with offices in Washington, D.C., and we represent the Home Beneficial Life Insurance Company of Richmond. Table I on page 12 of the report lists Home Beneficial as a major seller of cancer insurance. They do not sell this type of coverage, and, in fact, have never sold it. In support of this, we are endeavoring to obtain a letter from the Insurance Bureau of Virginia, and the company will also affirm this by affidavit to the Committee. Unfortunately, their being cited in the report as a seller of cancer insurance has been reported by the media and, consequently, the company is desirous of correcting this as promptly as possible.

I might add that members of your office and the Committee staff have been most helpful and cooperative. In examining the report, on pages 179, 180 and 181, there's a possibility that confusion may have occurred between Home Beneficial Life Insurance Company of Virginia and Home Life Insurance Company of New York.

In all events, I would be most grateful for anything you and members of your committee and staff might do to correct the situation I have described to you.

With kindest personal regards, I am

Sincerely,

Jack

John O. Marsh, Jr.

Attachment

73/392

cc: The Hon. David E. Satterfield
The Hon. William C. Wampler

ADDITIONAL PREPARED STATEMENTS

STATEMENT OF REPRESENTATIVE CHARLES E. GRASSLEY

"Cancer Insurance Industry"

MR. CHAIRMAN, I join the other members of the House Select Committee on Aging in expressing my pleasure at this opportunity to work together with our Senate colleagues in addressing the subject of this hearing.

An investigation by our committee leaves little question that cancer insurance, as distinct from general health insurance is, in most cases, a poor investment. Our investigation also reveals that many companies selling this form of insurance engage in sales tactics which exaggerage the incidence of cancer and pander on fear in order to induce the purchase of their policies. As we shall hear today, many of these policies return little if any of the benefits that the purchaser is led to expect.

Since the incidence of cancer tends to increase with age, the elderly are especially vulnerable to hoax by unscrupulous agents and insurance companies. The desire of the elderly to protect others from the high cost of cancer treatment makes them easy prey to those who exploit such honorable motivation for the purpose of selling spurious security.

This hearing will reveal specific instances of such practice. Since the regulation of insurance is a state responsibility, I hope that the print of the hearing will be sent to every state director or commissioner of insurance. We must do all that is properly within our province to rid the insurance industry of practitioners who operate at this unsavory and deceptive level of business.

I commend the members of the Senate Subcommittee on Antitrust, Monopoly and Business Rights for its good conscience and initiative in calling this hearing.

# # #

CITY OF WEST HELENA
ARKANSAS
Municipal Building • 99 Plaza Street

R. E. TESTER, Mayor
JAMES A. BOGLE, Treasurer
J. S. ADKINS, City Clerk

HARVEY L. YATES, Municipal Judge
R. C. MURRAY, City Attorney
JAMES T. CROSS, Chief of Police
EARL T. MEIERS, Fire Chief

March 17, 1980

AFFIDAVIT

STATE OF ARKANSAS)
: SS
COUNTY OF PHILLIPS)
: SS
CITY OF WEST HELENA)

My name is William W. Sturgeon. I live at 40 Edgewood Circle, West Helena, Arkansas. I am a retired foreman from the Chicago Mill & Lumber Company in West Helena, Arkansas. I am a volunteer member of the West Helena Fire Department. I have been a member of the Auxiliary Fire Department for West Helena for approximately 20 years. We don't get much pay for our firefighting services because our town of about 12,000 people over in the Delta along the Mississippi River valley can't afford all full time firemen. The volunteer fire department is a civic as well as a social club. We meet twotimes a month and go to most of the fires to help the few regular full time firemen protect the homes in our town.

In 1968 I took out, along with other firemen, a cancer insurance policy with American Family Life Assurance Company of Columbus, Georgia. The agents when they appeared before us at the City Hall in West Helena to get us to buy the policies told us in 1969 that if we had cancer the benefits would be paid even if we were in the Veterans Hospital and regardless of any other benefits we might have. I kept my policy up. In 1975 I began having trouble with my throat and was hospitalized by my family doctors in our local hospital. I was ultimately hospitalized and operated on for cancer in the Veterans Hospital in Memphis. Our local county Helena Hospital bill was $979.55. I was hospitalized seven days. That bill has never been paid. I was hospitalized at the VA Hospital in Memphis on three different occasions; 28 days; 19 days; and 5 days; I have never been paid benefits for those periods of time.

I paid premiums from 1968 on the group policy up through the time I retired which was in September of 1975 and after retiring I began to pay the premiums on a non-group basis and paid the premiums up until 1976. My Helena Hospital bill has never been paid. My benefits due me while I was hospitalized in the Veterans Administration Hospital and in our local county hospital have never been paid.

I understand, Senator, you and your committee are investigating abuses in the insurance industry. I definitely feel that American Family Life Assurance Company of Columbus, Georgia has taken advantage of me and has done me wrong. I have worked hard for my money and I have paid these premiums and they have never paid the benefits. I urge that you and the federal government stop these abuses by the insurance industry. It's not fair for this company to take my money and not pay me the benefits. This has kept me torn up for many years.

This has made my health problems greater.

W. W. Sturgeon

W. W. STURGEON

Subscribed and sworn to before E.L. Schieffler, the undersigned Notary Public, on this the 17th day of March, 1980.

(SEAL)

NOTARY PUBLIC

My Commission Expires:

1-30-84

best copy available

CITY OF WEST HELENA
ARKANSAS
Municipal Building • 99 Plaza Street

R. S. TEETER, Mayor
JAMES A. BOGLE, Treasurer
J. S. ADKINS, City Clerk

HARVEY L. YATES, Municipal Judge
R. C. MURRAY, City Attorney
JAMES T. CROSS, Chief of Police
EARL T. [illegible], Fire Chief

March 17, 1980

AFFIDAVIT

STATE OF ARKANSAS)
: SS
COUNTY OF PHILLIPS)

My name is Oscar Sanford. I am a retired Captain of the West Helena Fire Department. I worked for the fire department of West Helena for approximately 21 years. I know W. W. "Jack" Sturgeon. I was present in 1969 when the American Family Life Assurance Company sold Jack his policy to protect him against cancer. Many of us firemen bought these policies after the company told us how good the policies were. There were several veterans in the fire department. The company said that the benefits would be paid even if the fireman was a veteran and went into a government hospital and would pay regardless of other benefits the fireman had. Mr. Sturgeon kept the policy all the time that he was on the Auxiliary Fire Department. When he retired, he then kept the policy on a non-group basis. I am upset that the insurance company, after it was discovered that Jack had cancer of his throat, didn't pay his benefits and still to this date have not paid his benefits. Senator, I for one would urge you to continue your investigation and are hopeful that you and your

Affidavit of Oscar Sanford, continued, March 17, 1980

staff and Congress will adopt federal laws to prevent cancer insurance companies from abusing and taking advantage of people such as Mr. Sturgeon and other firemen.

Oscar Sanford
OSCAR SANFORD

Subscribed and sworn to before me this 17 day of March, 1980.

(SEAL)

NOTARY PUBLIC

My Commission Expires:
1-30-84

CITY OF WEST HELENA
ARKANSAS
Municipal Building ● [illegible]

[illegible], Mayor
[illegible], Treasurer
[illegible], City Clerk

[illegible], Municipal Judge
R. C. MURRAY, City Attorney
JAMES T. CROSS, Chief of Police
[illegible], Fire Chief

March 17, 1980

AFFIDAVIT

STATE OF ARKANSAS)
: SS
COUNTY OF PHILLIPS)

My name is Roy Deaton. I was a member of the West Helena Auxiliary Fire Department. I was a member of that for 13 years. I know Mr. W. W. Sturgeon personally. I was there when they sold Mr. Sturgeon his policy. They convinced us that this was a good policy and that it would pay benefits if one of us had cancer. They indicated that they would pay regardless of whether or not we were in a private hospital or government hospital and regardless of what other benefits we might have.

I am familiar with the W. W. Sturgeon claim and I am quite put out as to the way they have treated Mr. Sturgeon. I urge that your committee continue your investigation and take appropriate actions to make sure that this insurance company never hurts anyone like

Affidavit of Roy Deaton, continued, March 17, 1980

they have hurt Mr. Sturgeon by taking his money and not paying the benefits.

ROY DEATON

Subscribed and sworn to before me this 17th day of March, 1980.

(SEAL)

NOTARY PUBLIC

My Commission Expires:
1-30-81

CITY OF WEST HELENA
ARKANSAS
Municipal Building • 99 Plaza Street

R. E. YESTER, Mayor
JAMES A. BOGLE, Treasurer
J. E. ADKINS, City Clerk

HARVEY L. YATES, Municipal Judge
R. C. MURRAY, City Attorney
JAMES T. CROSS, Chief of Police
EARL T. MEIERS, Fire Chief

March 17, 1980

AFFIDAVIT

STATE OF ARKANSAS)
: SS
COUNTY OF PHILLIPS)
: SS
CITY OF WEST HELENA)

My name is Earl Meiers. I am the Chief of the Fire Department for West Helena, Arkansas. I know W. W. Sturgeon personally. I was present when the insurance agent solicited his and other firefighters cancer insurance. Our town of West Helena, Arkansas, is about 12,000 in population, It is located in the Mississippi River valley,in eastern Arkansas, West Helena is indebted to citizens such as W.W. Sturgeon. Our town can't afford a full time fully staffed fire department.

Approximately 20 men, including Mr. Sturgeon, for years as volunteer firefighters helped protect the homes in our town from fires. They respond to the fire alarms along with us full time firefighters.

It hurts me to see how Mr. Sturgeon has been treated by this cancer insurance company. The firemen in 1968 took out a group policy with this company. Mr. Sturgeon was a member of that group policy. He later retired from the volunteer fire department and kept the policy himself. The firefighters and Mr. Sturgeon personally paid premiums for many years.

Mr. Sturgeon was diagnosed as having cancer in 1975; he was hospitalized in a hospital at home and several times at a government hospital in Memphis. Mr. Sturgeon has been trying to get the insurance company for several years to pay the hospital bills and his benefits but they have not paid them. The insurance company stated that they would pay the benefits even though the patient were in a government hospital.

Several years later, they issued another policy, a policy that I bought that states they will not pay cancer benefits if you are in a government hospital. Mr. Sturgeon had his policy out earlier and that policy stated it would pay regardless of other benefits and regardless of whether or not hospitalization was in a government hospital.

They changed the policy without Mr. Sturgeon's approval.

Many of the other members of our fire department are disturbed over how our friend and fellow firefighter, Jack Sturgeon, has been treated by the American Family Life Assurance Company of Columbus, Georgia.

I have with me affidavits of several other firefighters who have personal knowledge as to how the insurance company solicited the insurance business. Mr. Chairman, with your permission I would like to file these affidavits along with this statement and the statement of Mr. Sturgeon. I, personally, and on behalf of the members of the West Helena Fire Department appreciate you and your committee's investigation. We hope that you will be able to stop these abuses of cancer insurance companies.

EARL MEIERS, CHIEF OF FIRE DEPARTMENT
West Helena, Arkansas

Subscribed and sworn before E. L. Schieffler, the undersigned Notary Public, on this the 17th day of March, 1980.

(SEAL)

NOTARY PUBLIC

My Commission Expires:

1-30-84

ADDITIONAL SUBMISSIONS FOR THE RECORD

SUBMISSIONS OF MRS. MARIAN SOBIESIAK

LEHIGH INTERNAL MEDICINE ASSOCIATES, LTD.
LITTLE LEHIGH MEDICAL BLDG.
1275 S. CEDAR CREST BLVD.
ALLENTOWN, PENNSYLVANIA 18103
Phone (215) 439-0300 or 434-7735

PRACTICE LIMITED TO
INTERNAL MEDICINE

JONATHAN W. BORTZ, D.O.
THOMAS V. BRISLIN, D.O.
HARVEY T. STARR, D.O.

February 20, 1980

Re: Sigmund Sobiesiak

TO WHOM IT MAY CONCERN:

Mr. Sigmund Sobiesiak is a patient of our Group and was hospitalized initially May 24th, 1979 at Allentown Osteopathic Hospital. After an extensive work-up he was found to have signet ring carcinoma of the bladder with pelvic metastasis. This was diagnosed on an operative procedure because of bilateral hydronephrosis by Dr. Robert Sherman on May 30th, 1979. At that time bladder biopsy was done and confirmed the diagnosis of signet ring carcinoma of the bladder.

I hope this information is of help.

Sincerely yours,

Harvey T. Starr, D.O.

HTS/lh

Robert J. Sherman, D.O.
UROLOGY
1422 HAMILTON STREET
ALLENTOWN, PENNA. 18102
435-2261

February 22, 1980

Re: Sigmund Sobiesiak

To whom it may concern:

Mr. Sobiesiak was first seen on consultation at the Allentown Osteopathic Hospital on 5/28/79. A work up was carried out on 5/30/79 including: cystoscopy, urethroscopy, bladder biopsy, and a transrectal biopsy of the prostate. The results of this work up revealed a cytologic classification of class V cells, and the tissue report showed tissue from the bladder consistent with adenocarcinoma of the signet ring cell type and tissue from the prostate consistent with metastasis of adenocarcinoma of the signet ring cell type.

Surgery was carried out on 6/4/79 which included the following:

1. Suprapubic cystotomy
2. Multiple bladder biopsies
3. Partial bladder resection
4. Bilateral nephrostomies
5. Bilateral pyelotomy

The patient currently has a bilateral nephrostomy and colostomy and is satisfactory at this time.

If I can be of any further help to you in regard to Mr. Sobiesiak's condition, please feel free to call upon me.

Sincerely,

R. J. Sherman

R. J. Sherman, D.O., F.A.C.O.S.

RJS/kel

LLOYD E. ESLINGER, D.O.
1740 LINCOLN AVENUE
NORTHAMPTON, PA. 18067
—
[illegible]

2/20/80

Re: Sigmond Sobiesiak

I treated the above named patient for several years for hypertension and sinusitis.

I had no knowledge that he had cancer or malignancy nor did he exhibit signs of same until May 22, 1979.

Lloyd Eslinger D.O.

LLOYD R. ESLINGER, D.O.
1748 LINCOLN AVENUE
NORTHAMPTON, PA. 18067
[illegible]

Sigmond Sobiesiak

Professional Services

1-9-79-	Office Visit - Blood Pressure Check -	$12.00
1-30-79-	" " " " "	12.00
2-20-79-	" " " " "	12.00
4-10-79-	" " "	12.00
5-22-79-	" " Abdominal Distention	13.00
7-31-79-	" " B.P. Check	13.00
		$74.00

Paid

Essential Hypertension
Chronic Sinusitis

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
HARRISBURG
17120

October 25, 1979

Telephone (717) 787-2317

The Union Fidelity Life Insurance Co.
Union Fidelity Office Park
Trevose, PA 19049

CONSUMER AFFAIRS
OCT 30 1979

Attention: Harry T. Dozor, Chairman of the Board

Re: Dept. File 79-155-7073
Union Fidelity Life Insurance Co.
Policy No. 6992240
Sigmund Sobiesiak

Dear Mr. Dozor:

I have addressed this letter to you because I wish you to personally intercede in this complaint.

This Department, at the request of the wife of your above captioned policyholder and claimant, has been engaged in correspondence with your claims department because of your company's denial of benefits for Mr. Sobiesiak.

The denial has been based on your contention the condition manifested itself prior to the expiration of 30 days from the effective date of the policy.

In the most recent letter dated October 10, 1979 Marilyn Segal informs me that information previously supplied me clearly indicates Mr. Sobiesiak has "increased in abdominal girth, hematuria, urgency and dysuria and other distinct urinary symptons prior to May 22, 1979."

She continues this case has been reviewed by your medical director, Dr. Albert Order who "agrees that these symptoms indicate that cancer began prior to May 22, 1979 and would have caused an ordinary prudent person to seek diagnosis, care or treatment."

I would ask that you furnish a statement, signed by Dr. Albert Order, stating that Sigmund Sobiesiak had cancer prior to May 22, 1979 and that his diagnosis is based not on subsequent events, but is based alone on the history of conditions as stated by Mr. Sobiesiak on May 22, 1979.

In my opinion your company is using a frivolous excuse to deny what I believe is a valid claim.

I will be grateful if you will have this file reviewed and give me your company's denial decision in this matter.

I will refrain from recommending any course of action to Mrs. Sobiesiak until I hear from you.

Sincerely,

James E Dumm

James E. Dumm
Investigator

JED:jm

cc: Mrs. Sigmund Sobiesiak

787-2317

March 10, 1980

The Union Fidelity Insurance Company
Union Fidelity Office Park
Trevose, PA 19049

Attention: John Cooney, President

Re: Dept. File 79-155-7073
Union Fidelity Insurance Co.
Policy No. 6992240
Sigmund Sobiesiak

Dear Mr. Cooney:

A review of this file reveals that I first wrote to your company September 12, 1979 in response to a request for assistance from Mrs. Sobiesiak.

There have been several letters exchanged between your company and this Department, the most recent of which was my letter dated January 22, 1980 addressed to Vice President Thomas L. Finnegan. In addition to the letter I have called Mary Vought on three occasions and I called Mr. Finnegan's office on February 29, 1980. I requested Mr. Finnegan's secretary to have him call me.

I have received neither letter nor a phone call from Mr. Finnegan.

I am now instructed by my superiors to invite your company to a meeting in my office on the 13th Floor, Strawberry Square, Harrisburg, Pennsylvania 17120 at 10:30 AM, March 28, 1980. Please have your representative prepared to discuss this file and to furnish any information in your possession, in addition to the unsigned history and physical examination allegedly conducted at the Allentown Osteopathic Hospital. There is no date on this unsigned history and examination. I would especially appreciate any statement that your medical officer, Dr. Order might like to provide.

It is unfortunate that we find it necessary to expose your company to the time loss and the expense of this meeting but it is obviously impossible to reconcile the problem and analyze the facts in any other way.

If you find this time and day inconvenient, please call me and I will be happy to arrange a mutually agreeable time.

Respectfully,

James E. Dunn, Investigator
Policyholders Service Division

JED:ja

cc: Richard A. Sebastian, Director
Niles L. Gross, Regional Manager
Mrs. Sigmund Sobesiak

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
HARRISBURG
17120

Telephone: (717) 787-2317

November 13, 1979

11/22/79

RECEIVED
NOV 15 1979
LEGAL DEPT.

Union Fidelity Life Insurance Co.
Union Fidelity Office Park
Trevose, PA 19047

Attention: Thomas L. Finnegan, Jr., Vice President - Legal

Re: Department File No. 79-1-55-7073
Union Fidelity Life Insurance Co.
Policy No. 6992240
Sigmund Sobiesiak

Dear Mr. Finnegan:

I appreciate your letter dated November 1, 1979 in regard to your above-captioned claimant.

You indicate your company has denied benefits based on a "careful consideration of all available materials submitted on Mr. Sobiesiak's behalf". You refer to the records of the Allentown Osteopathic Hospital and state they "clearly show that your insured had an increase in abdominal size for three months prior to his admission".

On October 10, 1979, Marilyn Segal quoted Dr. Albert Order and again referred to "increase in abdominal girth (painless), hematuria, urinary urgency and dysuria". She said Dr. Order agrees these symptoms indicate "cancer began prior to May 24, 1979 and would have caused an ordinary prudent person to seek diagnosis, care or treatment".

In my letter of October 25, 1979, I requested a statement, signed by Dr. Albert Order, stating that Sigmund Sobiesiak had cancer prior to May 22, 1979, and that his diagnosis was based not on subsequent events but was based alone on history of conditions as they existed on May 22, 1979. You have ignored this request. I once more make this urgent plea.

I do not wish to seem facetious, but really Mr. Finnegan, everyone of the symptoms of "painless increase in abdominal girth, hematuria, urinary urgency and dysuria" would be present in me if I were to drink a few extra bottles of beer for a few weeks. Would Dr. Order say I had cancer based on these symptoms alone and refer to me as being imprudent if I did not seek diagnosis and treatment!

Cancer, to a lay person, is associated with violent pain and loss of weight. Your Dr. Order says a prudent man should associate painless increase in girth with cancer.

Please keep in mind Mr. & Mrs. Sobiesiak are unsophisticated people not learned in medical terminology or symptoms.

You refer to the fact you have obtained expert evaluation of the medical records in this case. Has any opinion other than Dr. Order's been obtained? I would sincerely appreciate a statement signed by Dr. Order rather than by you or Ms. Segal.

Once more I ask you and your company to furnish a statement by Dr. Order, or any other qualified doctor, stating that in their opinion based on the symptoms alone Mr. Sobiesiak had cancer prior to May 22, 1979.

I will be grateful for your indulgence and cooperation.

Sincerely,

James E Dunn

James E. Dunn
Investigator

JED:bd

cc: Mrs. Sigmund Sobiesiak

Interoffice Memorandum

Office of the Attorney General

To: All Employees Acquiring Cancer Insurance Through Payroll Withholding

From: William J. Brown, Attorney General

Date: October 30, 1978

Subject:

During this summer, our Office conducted an investigation into the benefits derived by persons purchasing cancer insurance from the American Family Life Assurance Company AFLA) through the payroll withholding plan. Our investigation found that the AFLA policies provide little additional benefits over existing state hospitalization and disability plans. We also found that the claims made by AFLA in selling their policies were exaggerated and that more comprehensive coverage could be purchased for the same or lower cost.

As a result, I requested that the Department of Administrative Services withdraw withholding privileges to AFLA as of the November 30, 1978 pay period. Should you wish to continue coverage, it will be necessary for you to make arrangements directly with AFLA.

Attached to this notice is a copy of the memorandum which states in detail the findings that we made. Should you have any questions about the investigation, you should contact either Joseph M. Paul or Howard Petricoff at 1560.

cc: All Section Chiefs
(Please Post)

WJB

Interoffice Memorandum

Office of the Attorney General

To: **Richard D. Jackson, Director of Administrative Services**

From: **William J. Brown, Attorney General** WJB

Date: **October 30, 1978**

Subject: **American Family Life Assurance Company's Use Of The Payroll Deduction To Market Cancer Insurance**

The American Family Life Assurance Company of Columbus, Georgia (AFLA) has been marketing and selling to employees of the State an insurance policy that provides hospitalization benefits to those persons who contract cancer during the period of coverage. Payment for the policy is made through a monthly payroll deduction.

The cancer insurance coverage sold by AFLA covers only one disease, cancer. The policy provides for certain benefits to the insured only during a time he or she is hospitalized with cancer. This is an important limitation on coverage because much cancer treatment is on an out-patient basis.

Cancer insurance or dread disease coverage, as it is sometimes called, has been criticized by both consumer advocates and insurance experts. A spokesperson for the American Cancer Society has stated that the Society discourages the purchase of cancer insurance and also objects to the use of its figures to sell these policies. They say that the figures are accurate but that salespeople often use them out of context. For example, when a salesman states that cancer will strike one out of every four persons, he does not say that this figure includes many kinds of curable cancer, some of which do not involve costly treatment.

The National Cancer Foundation, a social service agency in New York City which provides professional counseling and care at home for advanced cancer patients and their families, has criticized any disease by disease approach to health insurance. It found that most cancer policies provide no coverage for care at home where substantial costs, such as housekeeping, nursing and medicine are incurred. The Foundation has also observed that some policies are carefully worded to minimize hospital and physician benefits. This is true of the AFLA policy. For example, AFLA provides payments for hospital chemotherapy but not for out-patient chemotherapy. Additionally, there is even a dollar limitation on the hospital treatment.

More disturbing, AFLA's generally skimpy coverage does not match existing state programs. For example, the group Blue Cross plan already provides all the coverage supplied by AFLA's offered policies. In fact, not only won't the AFLA policies provide additional coverage for medical cost, which is the primary reason listed for obtaining the insurance, but AFLA will not even provide the double coverage to members of our group Blue Cross program. Under the coordination of benefits clause of the group Blue Cross program, for every dollar provided by another medical insurance company, group Blue Cross reduces its payment one dollar. In other words, for any of our employees who belong to group Blue Cross the additional premiums paid to AFLA buys no additional medical coverage. I might add that most of our employees do participate in Blue Cross plan.

AFLA representatives were contacted and questioned on coordination of benefits. AFLA representatives agreed that if Blue Cross coordinated benefits, their cancer policies would be of little benefit, but they claimed that a special rider had been attached to the master policy coverting the AFLA cancer policy to disability insurance in the event of coordination. Unfortunately, the agents did not have a copy of the rider and previously had not filed a copy with the personnel department.

The Company subsequently mailed a copy of the rider. The rider provided that if a beneficiary was eligible for medical benefits and was being subject to coordination of benefits, the AFLA medical benefits would convert to disability benefits based on a flat fee per day of hospitalization. Although, the AFLA rider refers to those payments as "disability" they are contingent upon hospital confinement when cancer has been officially diagnosed. Currently, the state provides a true disability coverage for those who cannot work for any reason, including those confined to hospitals with cancer. The state retirement fund, however, does not supply 100% of salary for those disabled. An employee can purchase coverage up to 100% of salary for a modest premium from a private carrier. For example, a 30 year old employee making $8,000 can get 100% disability coverage for less than the AFLA cancer premiums.

If it appears that AFLA premiums provide little in the way of benefits, last year's cost/benefit figures filed by AFLA with the Ohio Department of Insurance confirms that appearance. For health and accident benefits AFLA paid out in Ohio only 40% of the premiums it collected in the state. This compares with 90% of premiums paid out by Blue Cross. Nor was last year in Ohio atypical for AFLA. Failure to pay out benefits, high commissions and unconscionable dividends (AFLA is a stock corporation) caused the states of New York, New Jersey and Connecticut to ban AFLA and other cancer insurance policies within their respective states.

I am not recommending a state wide ban or administrative action against AFLA at this time. However, in light of AFLA's failure to dove tail with existing state programs and its poor benefits record, I do recommend that the free use of state facilities (payroll withholding) (See Ex. B), and the implied state endorsement in AFLA's promotional material be terminated at once.

cjm

Enclosures

THE STATE TEACHERS
RETIREMENT SYSTEM OF OHIO

275 EAST BROAD STREET • COLUMBUS 43215
TELEPHONE 227-4090
AREA CODE 614

IN REPLY PLEASE REFER TO NUMBER

JAMES L. SUBLETT
EXECUTIVE DIRECTOR

VICTOR A. MILLER
DEPUTY EXECUTIVE DIRECTOR

ASSISTANT EXECUTIVE DIRECTORS
ALAN D. BROWNING, INVESTMENTS
BERNARD E. DIEHL, FINANCE & CONTROL
C. JAMES GROTHAUS, MEMBER BENEFITS
J. ALAN STEELE, DATA PROCESSING

November 6, 1978

Honorable William J. Brown
Attorney General of Ohio
30 East Broad Street
Columbus, Ohio 43215

Dear Mr. Brown:

I read with interest the newspaper accounts of your protest regarding the withholding privilege granted American Family Life Assurance Company for its cancer insurance plan. You should receive the commendation of every state employee for this action. Hopefully, Mr. Jackson will heed your recommendation.

The record of this company is notorious and the meager benefits provided by it are virtually valueless, especially when considered in relation to the excellent comprehensive coverage available to state employees.

In administering the Ohio Retirement Systems Health Care Plan, this cancer policy is a constant source of difficulty. Despite all our efforts, the company continues to push the policy and we have many hundreds of retired public employees spending money they can ill afford for coverage which is not only meager, but totally duplicates the ORS coverage.

Respectfully,

Jim

James L. Sublett
Executive Director

JLS/o

COMMODITY FUTURES TRADING COMMISSION
2033 K Street, N.W., Washington, D.C. 20581

James M. Stone
[illegible]

March 18, 1980

Honorable Howard M. Metzenbaum
Chairman
Subcommittee on Antitrust, Monopoly
and Business Rights
United States Senate
Washington, D.C. 20510

Honorable Claude D. Pepper
Chairman
Select Committee on Aging
U.S. House of Representatives
Washington, D.C. 20515

Gentlemen:

Your staff was kind enough to send me a copy of a draft report entitled "Cancer Insurance: Exploiting Fear For Profit." I have read it with great interest. It is a well presented and thorough document; I hope the Congress will take guidance from it.

When I was the Insurance Commissioner of Massachusetts, I initiated market conduct audits of several leading cancer insurers. The findings convinced me that sales of cancer insurance should be banned or severely limited. My staff was in the process of writing a full report on our recommendations when I left Massachusetts to assume my current job. Enclosed is a draft of that report which may serve as a useful supplement to the market conduct audit materials already in your possession. As you can see from the date of the draft, I was no longer in Massachusetts at the time of its preparation and I do not know if the report was ever released. Since this draft is not a final document, you should use your own judgment about the appropriateness of putting it on the record.

I would like to congratulate you on your courageous attempt to protect the innocent victims of unscrupulous insurance practices. If I can be of service, please let me know.

Very truly yours,

James M. Stone

Enclosure

A STUDY OF CANCER INSURANCE

(DRAFT ONLY)

Prepared by

The Research and Education Staff

Massachusetts Division of Insurance

May 29, 1979

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INTRODUCTION

Of the diseases that afflict humanity, Americans fear cancer most. According to one recent study, 58% of Americans rank cancer as their foremost health concern.(1)

Responding to the evidence of widespread fear and concern about cancer, a number of insurance companies now market specialized cancer insurance policies. These policies are needed, say the insurers, to protect consumers adequately against the high costs of cancer care.

In 1978, the leading cancer insurer generated nearly $300 million in cancer insurance sales and predicted a 33% increase, to $400 million, for 1979.(2) Millions of cancer insurance policies are now in force, and each year brings a dramatic surge in the total number of new policies sold.

Although cancer insurers regard all families as potential buyers of their product, some groups have proved especially responsive to their sales campaigns. Among the Massachusetts policyholders of one large cancer insurer, for example, a recent survey showed a preponderance of elderly consumers. Twenty-six percent of all policyholders were in their sixties, 46% in their seventies, and 7% in their eighties.(3)

As the public spends more and more money on cancer insurance, consumer organizations and government agencies have become increasingly concerned about the value of this coverage and the methods by which it is sold. After examining benefits provided by several common cancer policies, *Consumer Reports* recently cautioned it readers against the purchase of the policies:

> The cost of cancer treatment is often fearfully high. Nevertheless, we don't recommend buying cancer insurance. The cancer insurance policies CU [Consumers Union] examined offer only fragmentary protection against the cost of treatment. And they offer no coverage at all for numerous diseases that can also be expensive to treat. On balance CU thinks any money spent on cancer insurance would be better spent on improving your broad health insurance coverage.(4)

Reaching similar conclusions, some state governments have also acted to restrict or ban the sale of cancer insurance. Eight state insurance departments have implemented specific "minimum standards" requirements that must be met within the varied list of cancer insurance benefits. The New York Insurance Department requires that cancer insurance not be sold at all, except as an add-on to broader "basic" or "major medical" policies. Citing the "inherently misleading" nature and promotion of cancer insurance, the New Jersey Insurance Department bans its sale entirely. The Connecticut State Legislature has also banned the sale of cancer policies.

To understand the strong criticism and strong regulatory action that cancer insurance has elicited in many quarters, it is useful to seek answers for several specific questions:

--How did cancer insurance get its start?

--How is it typically sold?

--Compared to its sales presentations, how well does cancer insurance actually perform?

--How great is the need for cancer insurance? Could another policy meet the need more effectively?

During late 1978, the Massachusetts Division of Insurance directed "market conduct" examinations of four health insurers that sell cancer policies -- American Family Life Assurance Company of Columbus, Georgia; American Income Life Insurance Company (Waco, Texas); Union Fidelity Life Insurance Company (Trevose, Pennsylvania); and Washington National Insurance Company (Evanston, Illinois). The Division assigned attorneys to examine marketing methods and policy forms; nationally known accounting firms to examine company expenses and claim payments; and a survey research firm to study samples of insureds.

Using data generated by these field examinations, and other sources of information, members of the Division's staff have attempted to piece together the answers to the most important questions about cancer insurance. They have examined, as well, the available options for regulation of this type of coverage.

Their findings and conclusions are presented in this report.

I. THE SELLING OF CANCER INSURANCE

There is an old saying that "insurance isn't bought, it is sold." Nowhere does this adage seem more true, or more fraught with consequences, than in the selling of cancer insurance.

A Heck of a Sales Force

Cancer insurance is the brainchild of John B. Amos, the founder and chairman of American Family Life Assurance Company of Columbus, Georgia. A 1977 Forbes magazine article relates that "when the debit insurance company he founded /in 1955/ with $55,000 of borrowed money and another $250,000 from outside sources went nearly bust three years later, Amos had to find something else to sell."(1)

Although they had never made a big splash in the marketplace, health insurance policies covering only one or several "dread" diseases -- including polio, encephalitis and diphtheria -- had existed since at least the 1940's. In his search for "something else to sell," Amos thought of developing a special policy for yet another dread disease:

> The incidence of cancer was high and growing, treatment was expensive and there would never be any epidemics to cover. A cure seemed a long way off, and the growing fear of cancer was almost universal. Why not offer an inexpensive. . . policy designed to span the gap between the limits of group medical coverage and the actual cost of protracted cancer treatment? /Emphasis added./(2)

American Family introduced such a policy in 1958.

If the fear of cancer was almost universal, Amos reasoned, the potential market for his new product would be the same. Determined to capitalize on this potential, he gradually developed selling strategies that were as shrewd as his original product idea.

One of these was "cluster selling." Door-to-door sales of individual health insurance policies were effective and rewarding, but it would have taken many years to tap a universal market using that method. The cluster selling method, introduced in 1967, permitted the mass merchandising of cancer insurance and a much more rapid growth of sales.

The method involves persuading employers to let American Family agents address their employees collectively, offering individual policies at a discount. Since the premiums are usually paid in monthly installments through payroll deductions, cooperating employers indirectly assume a portion of the selling cost. To many employees, the American Family sales presentation on the work premises and the availability of a payroll deduction payment plan also suggest an employer endorsement of the cancer policies.

Having devised a novel way to sell individual cancer policies to groups, Amos also planned an effective strategy for expanding sales into additional states. This involved a fronting arrangement with Chicago's Globe Life Insurance Company, which was already licensed to sell health insurance in most states.(3)

Globe introduced Amos' cancer policies into many of these states, and American Family reinsured them. When it later applied to these states for licensing in its own name, Amos' company could argue that its product was already being marketed there with no apparent problems. According to *Forbes*, "the scheme worked beautifully . . . Today [American Family] can sell in 47 states and Washington, D.C., plus Puerto Rico, the Virgin Islands, Great Britain, Lebanon, Hong Kong and Japan."(4)

Whether operating at home or abroad, Amos has always paid close attention to the proper motivation of his agents to maintain the desired growth of cancer insurance sales. G. Othell Hand, a baptist preacher and company vice president for motivation (and author of an exhortatory volume entitled *It's Easier to Win*), attends to agent morale. Agents whose names have disappeared from the company's list of top salesmen are likely to get calls asking, "Is everything all right at home? Any problems you'd like to talk about?"(5)

One dependable morale booster and sales incentive is the company's generous compensation package -- including commissions, stock bonuses and sales contest prizes -- for productive agents and regional managers. In 1976, four earned more than Amos' own annual pay of $160,000. Fifteen salespeople made more than $100,000.(6) The company pays its agents a commission of 50% of first-year premiums for policies sold door-to-door, and from 20%

to 49% for policies issued through cluster selling. The commission for all policy renewals is 10%.(7) Particularly in the case of accumulated cluster sales, such commission rates can make American Family agents rich men indeed.

Unlike previous dread disease policies, cancer insurance -- and the company that invented and aggressively marketed it -- have made a noticeable splash in the health insurance marketplace. A 1978 report by Equity Research Associates offers this assessment:

> When the business history of the 1970's is written, American Family Corporation will in all likelihood be ranked among the top half dozen or so growth companies of the decade. In 1970 it reported total revenues of $18 million generated primarily in the Southeastern region of the United States. By 1980, revenues on a broad base of U.S. and international business should approximate $500 million. After-tax profits by 1980 should triple the entire revenues of the company in 1970.(8)

Meanwhile, American Family's success has encouraged other insurers to develop their own cancer insurance policies and marketing techniques. One company, American Income, uses union lists and implied union endorsements to facilitate individual selling to members of employee groups. Its agents address union members as "brothers and sisters"; boast that American Income is "recognized by the AFL-CIO as a Union Label Company" because all its agents and office employees are unionized; and focus on the amount of insurance coverage that just one hour per week of wages can buy.(9)

Aggressive mail-order companies like Union Fidelity have added their distinctive sales techniques to the search for new cancer insurance prospects. Still other companies, using large forces of agents and more conventional selling methods, provide additional competition for group and individual sales.

In the face of growing competition, American Family estimates it is maintaining a market share of about 60% of cancer insurance sales and professes undaunted optimism about the future. If competitors make increasing inroads in cancer insurance sales, or if doctors come up with a cancer cure tomorrow, John Amos has no shortage of other ideas: "We could always do something else. Sell life insurance like nobody ever sold it before. Or maybe cosmetics. We've got a heck of a sales force."(10)

As Forbes has pointed out: "American Family is a hard-sell merchandising company that just happens to sell insurance."(11)

Cashing In on Fear

If cancer insurers sold square wheels or horse-drawn boats, neither cluster sales nor lavish sales commissions would assure their success. Clearly, high-power sales techniques work especially well for cancer insurance because the product offers protection against CANCER — and cancer is something that many people are concerned about.

As one victim put it, "Cancer provokes a lot of anxieties that, say, heart attacks don't. . . It's not only pain and death but. . . anxiety about the pervasive, crab-like thing that secretly invades, takes over, your body."(12) Death, pain and the constant threat of a drawn-out, frustrating disease feed the common fear of cancer.

In a 1978 financial report on American Family, Equity Research Associates bases much of its glowing evaluation on the fact that cancer is a "universal disease" and that cancer insurance has "universal applicability" which assures sustained sales. American Family is therefore an interesting investment opportunity, the report concludes, even though some investors might reject the thought of investing "in a company which makes a business out of people's fear of cancer."(13)

Consumer Reports, in a 1978 article entitled "Cashing in on Fear," has charged that cancer insurers deliberately exploit this fear to promote the sale of their policies.(14) For the record, spokesmen for the companies usually deny such charges. "We don't have to rattle skeletons," says John Amos. "We just explain the situation."(15)

However, for American Family and its growing list of competitors, "explaining the situation" appears -- from objective evidence -- to involve a good deal of skeleton-rattling. In its recent review of the marketing materials and practices of four cancer insurers, the Division of Insurance found a pattern of selling that depends essentially on evoking fears about this disease.

In truth, the lowest common denominator of all cancer insurance selling is the unabashed campaign to inform all consumers why, if they are not already scared to death of cancer, they unquestionably should be.

For example, American Family's full-page advertisements in Time and Reader's Digest have emphasized that "a special Gallup poll released to Parade Magazine recently showed that 58% of Americans fear being struck by cancer more than any other disease (blindness 21%, heart disease 10%, all others 2% or less)." The American people "are scared of cancer," say the ads, "and rightly so."(16)

Just why this is rightly so is a subject explored explicitly, graphically, and enthusiastically in nearly every advertisement, brochure and agent sales presentation examined by the Division. In many cases, these materials are misleading as well.

Bemoaning cancer incidence. The advertising brochures and agent sale presentations typically begin by emphasizing the high incidence of cancer. One Union Fidelity brochure prominently impresses upon the consumer, "55 MILLION AMERICANS WILL GET CANCER. . . 1 OUT OF EVERY 4 PEOPLE. IT WILL STRIKE 2 OUT OF 3

FAMILIES."(17) The company's direct mail letter adds, "If there are 75 families [living on your street], 50 of you will have cancer touch your lives."(18)

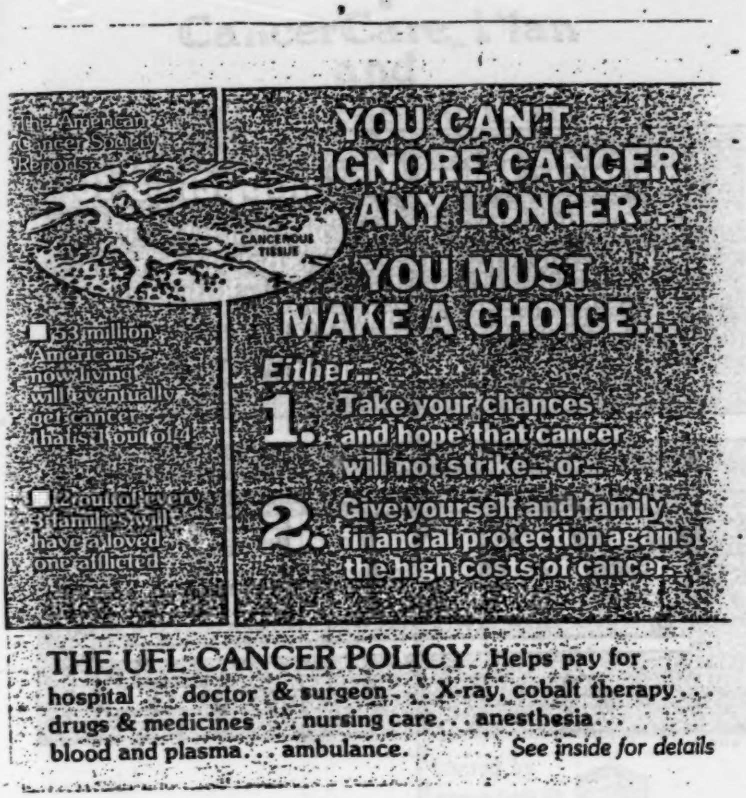
In case these statistics are not threatening enough, one Union Fidelity brochure, reproduced on the next page, also features a graphic depiction of a gnarled and menacing growth, identified as "cancerous tissue," spreading across a scarlet background.(19)

On the cover of several other brochures, in white type on a funereal black background, the company lists the names of celebrities who have died of cancer and warns: "The same thing that happened to [them] could happen to you. . . CANCER."(19a) An example is reproduced on page 10.

American Family's agent presentation also emphasizes the high incidence of cancer: "Did you know that cancer will strike, within a lifetime, 1 out of every 4 Americans, and 2 out of every 3 families? Among children, cancer is the leading killing disease. Cancer is the leading killer of women between 30-54. . . 54% of all cancer deaths are males."(20) A two-page brochure uses the entire front cover, reproduced on page 11, to present similar statistics.(21)

American Income's agents, displaying a notebook open to the two pages reproduced on pages 12 and 13, say:

> Cancer doesn't care whether you are rich or famous, strong or weak, or what, it strikes anybody. If Vince Lombardi, Babe Ruth, Nat King Cole and all of these other famous, even wealthy people, couldn't protect themselves from cancer, how can you and I? The truth, John, is that you can't. Neither can Mary.(22)



The American Cancer Society Reports:

CANCEROUS TISSUE

- ■ 53 million Americans now living will eventually get cancer— that's 1 out of 4
- ■ 2 out of every 3 families will have a loved one afflicted

YOU CAN'T IGNORE CANCER ANY LONGER . . .

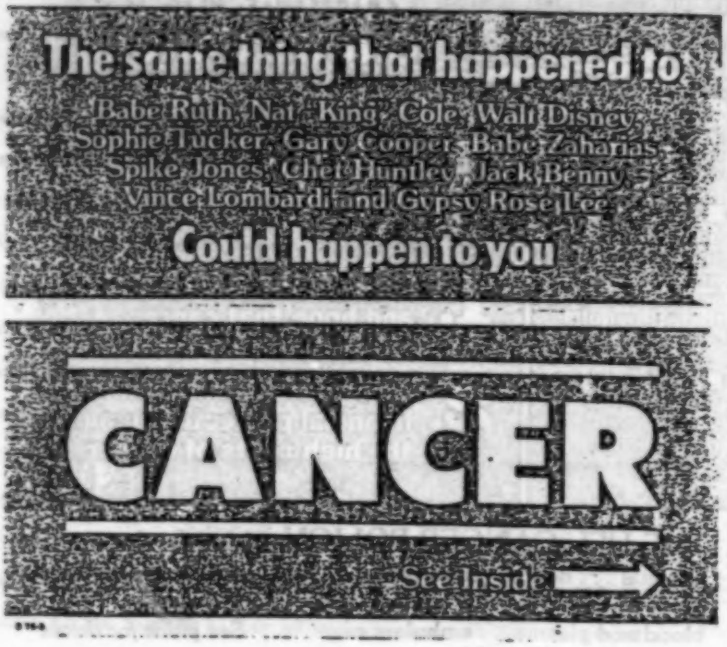
YOU MUST MAKE A CHOICE . . .

Either . . .

1. Take your chances and hope that cancer will not strike . . . or . . .

2. Give yourself and family financial protection against the high costs of cancer . . .

THE UFL CANCER POLICY Helps pay for hospital . . . doctor & surgeon . . . X-ray, cobalt therapy . . . drugs & medicines . . . nursing care . . . anesthesia . . . blood and plasma . . . ambulance. *See inside for details*



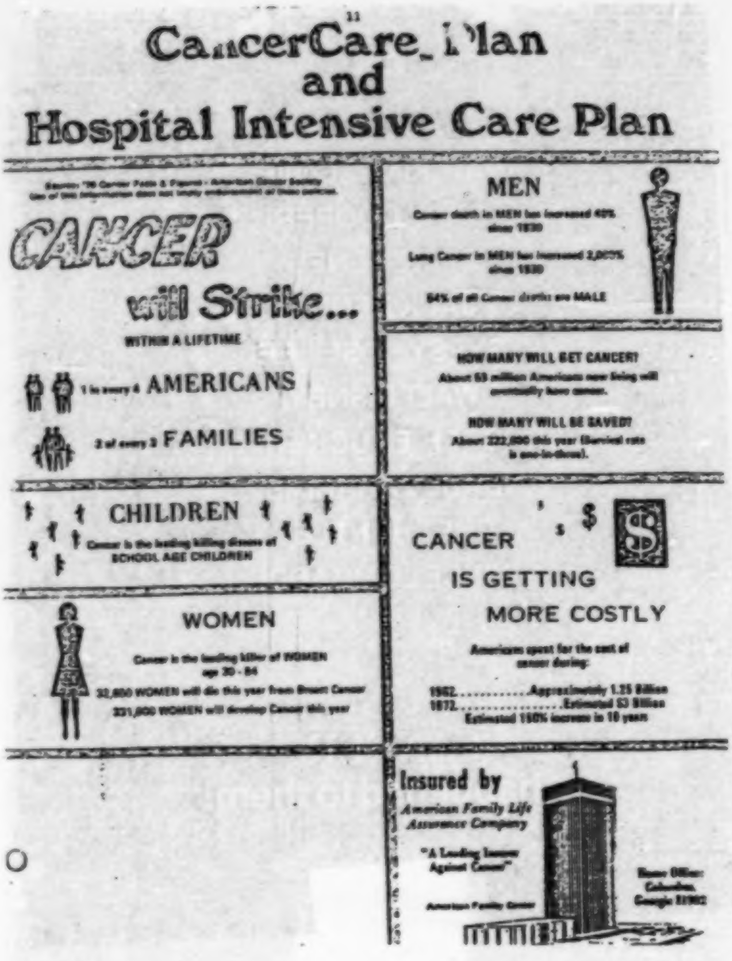
The same thing that happened to

Babe Ruth, Nat "King" Cole, Walt Disney,
Sophie Tucker, Gary Cooper, Babe Zaharias,
Spike Jones, Chet Huntley, Jack Benny,
Vince Lombardi, and Gypsy Rose Lee

Could happen to you

CANCER

See Inside



CancerCare Plan and Hospital Intensive Care Plan

Source: '76 Cancer Facts & Figures - American Cancer Society
[illegible]

CANCER will Strike...

WITHIN A LIFETIME

1 in every 4 AMERICANS

2 of every 3 FAMILIES

MEN

Cancer death in MEN has increased 40% since 1930

Lung Cancer in MEN has increased 2,000% since 1930

54% of all Cancer deaths are MALE

HOW MANY WILL GET CANCER?

About 53 million Americans now living will eventually have cancer.

HOW MANY WILL BE SAVED?

About 222,000 this year (Survival rate is one-in-three).

CHILDREN

Cancer is the leading killing disease of SCHOOL AGE CHILDREN

WOMEN

Cancer is the leading killer of WOMEN age 30 - 54

32,800 WOMEN will die this year from Breast Cancer

331,000 WOMEN will develop Cancer this year

CANCER IS GETTING MORE COSTLY

Americans spent for the cost of cancer during:

1962.............Approximately 1.25 Billion
1972.................Estimated $3 Billion
Estimated 150% increase in 10 years

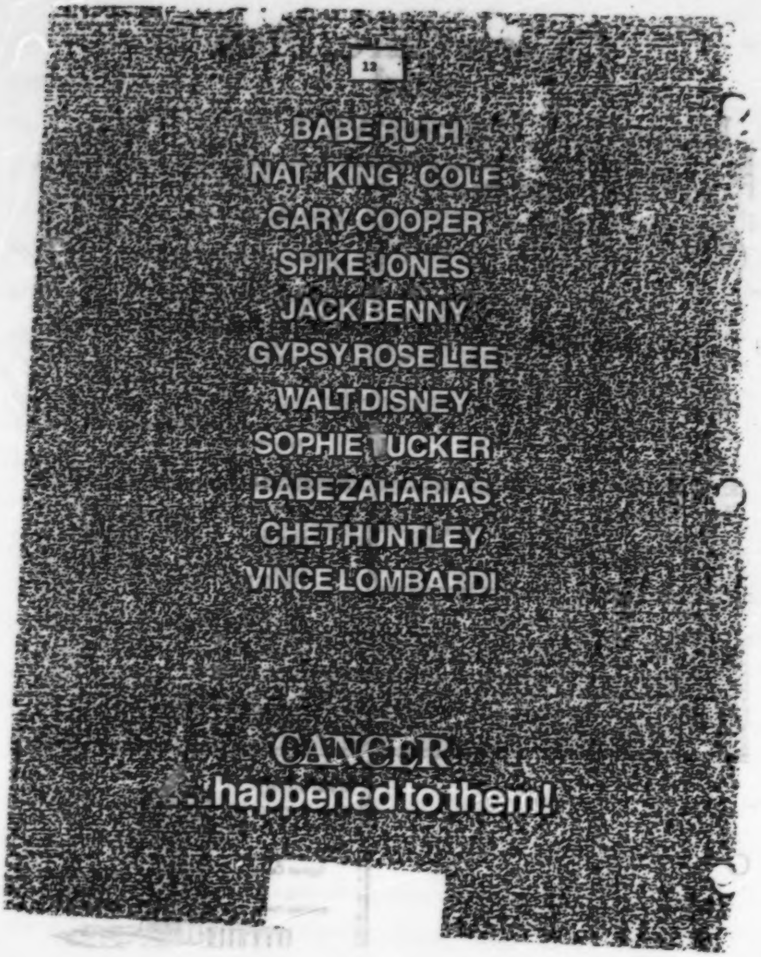
Insured by

American Family Life Assurance Company

"A Leading Insurer Against Cancer"

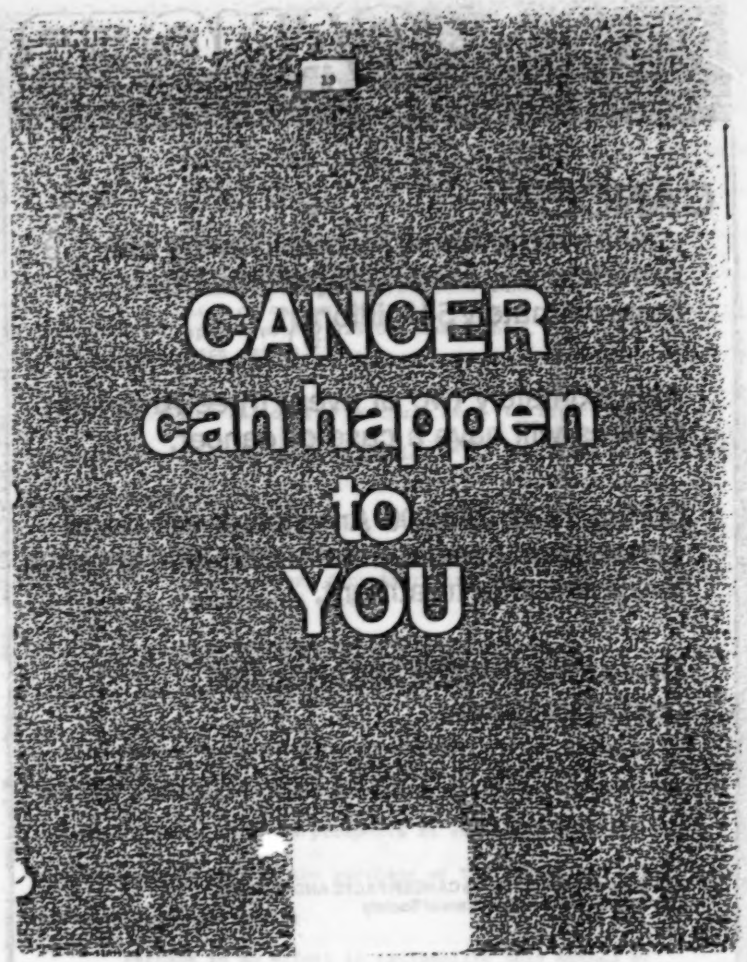
American Family Center

Home Office:
Columbus,
Georgia 31902

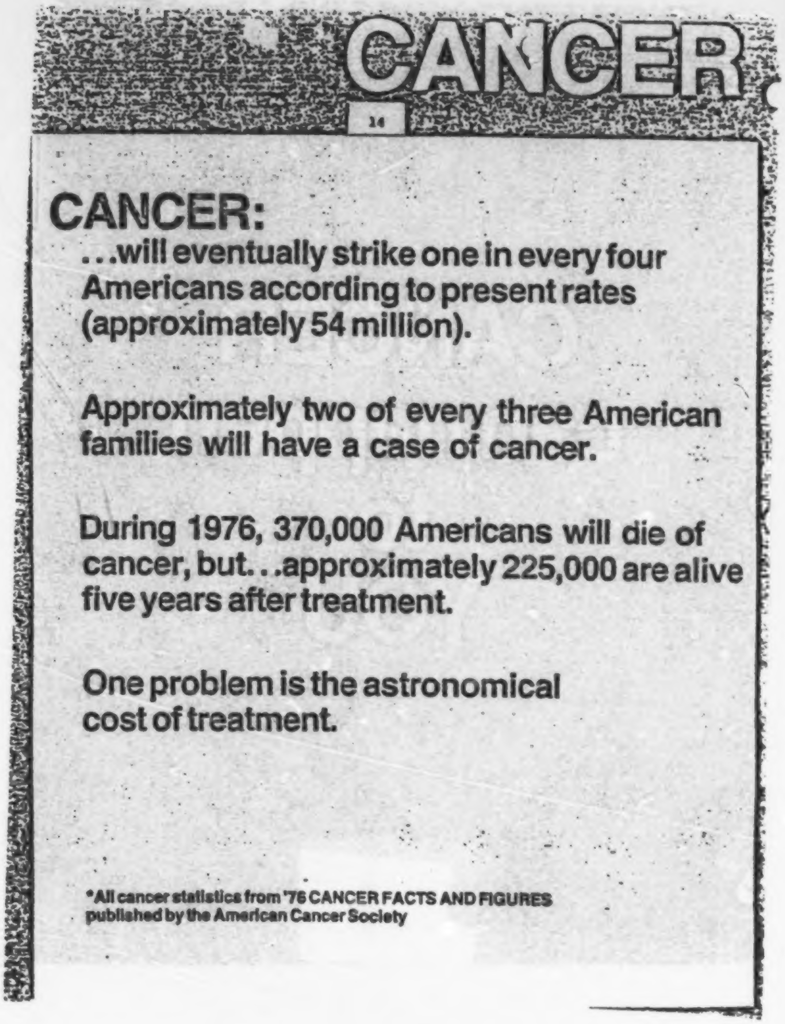


BABE RUTH
NAT KING COLE
GARY COOPER
SPIKE JONES
JACK BENNY
GYPSY ROSE LEE
WALT DISNEY
SOPHIE TUCKER
BABE ZAHARIAS
CHET HUNTLEY
VINCE LOMBARDI

CANCER
...happened to them!



CANCER
can happen
to
YOU



CANCER

CANCER:

. . .will eventually strike one in every four Americans according to present rates (approximately 54 million).

Approximately two of every three American families will have a case of cancer.

During 1976, 370,000 Americans will die of cancer, but. . .approximately 225,000 are alive five years after treatment.

One problem is the astronomical cost of treatment.

*All cancer statistics from '76 CANCER FACTS AND FIGURES published by the American Cancer Society

Then, the agents show another page (reproduced opposite) and recite:

> The American Cancer Society tells us that cancer will strike. . . one in every four Americans, according to present rates. . . more than 50 million Americans now living. . . and that approximately two out of every three American Families will have a case of cancer. It is estimated about 370,000 Americans died of cancer in 1976. . . but approximately 225,000 Americans were saved.(23)

Washington National's brochure uses statistics similar to those presented by the other companies.(24) The first page of the brochure states:

> Cancer is on the increase (It strikes one in every four Americans, two families in three)
>
> All ages are susceptible (It's the leading cause of death of women age 30-45 and of school children)

Common to all these cancer-frequency statistics, piled one atop another in profuse and grisly array, is the apparent attempt to evoke in sales prospects an emotional distress that can be assuaged only by the purchase of the prescribed antidote, a cancer insurance policy.

Perhaps in an effort to rationalize this method of "explaining the situation" about cancer, John Amos has asserted that "fear motivates the purchase and renewal of all insurance."(25) It is clear, however, that the cultivation of fear plays so large a role in regard to no other insurance product. Automobile accidents occur more frequently than cancer,(26) and can cause either death or painful and permanent disability; but auto insurance agents do not usually recite the grim statistics of accident carnage to sell policies. Heart disease kills more people than cancer, and costs more;(27) but companies selling basic health insurance (which covers heart disease and nearly all other illnesses) do not ordinarily compete for business through statistical polemics alleging the prime importance of that disease.

The statistics on cancer frequency used by all four companies are those of the American Cancer Society (ACS). In many of the selling materials, the name of the ACS is featured prominently and often as the source of the bad news about cancer. A spokesman for the Pennsylvania Division of the ACS has testified that such statistics are "presented usually in a way that indicates to the casual reader endorsement by the society. We have no doubt that many purchasers of Cancer Insurance believe that the ACS in some way approves the insurance."(28)

One insurer has been partially responsive to this complaint; American Family now uses a disclaimer in its sales brochures (though not in its agent sales presentation) saying "use of this information does not imply endorsement of these policies." But most have not.

The American Cancer Society's Pennsylvania Division also objects to the alarmist context in which its statistics are presented:

> ACS statistics are often used in promotional pieces to scare people. This fear tactic. . . is detrimental in terms of educating the public regarding steps they should take to protect themselves against cancer.
>
> Our goal is to control cancer. . . Early detection is the key to curing cancer. Fear of cancer can cause delay in seeking prompt medical attention at the earliest sign of something wrong.
>
> If such scare tactics and attempts to link the policy with a reputable organization are necessary to sell a particular insurance policy, one must question why it can't be sold on its merit alone.(29)

Although the American Cancer Society cautions that its estimates are offered "as a rough guide and should not be regarded as definitive,"(30) cancer insurers never reproduce this warning and usually present ACS projections of cancer incidence as though they were certain facts. American Family's agent presentation thus begins: "Mr. Jones, these facts come from the American Cancer Society. . ."(31)

Emphatic statements such as "cancer will strike 55 million Americans. . . 1 out of every 4 people. . . one every 45 seconds. . ." ignore the fact that no one can predict with certainty what the future incidence of cancer will be. One insurer's statement that "cancer is on the increase"(32) illustrates the folly of drawing definitive conclusions from existing data: According to the ACS 1979 Cancer Facts & Figures, "the overall incidence of cancer has decreased slightly in the past 25 years."(33)

Besides being made to suggest an unwarranted degree of certainty about future events, specific ACS estimates are also presented in ways that promote simplistic conclusions about the significance of cancer risk. For example, the often quoted estimate that "cancer will strike. . . one in every four Americans" could lead some consumers to conclude, erroneously, that one-quarter of the population now has cancer. The present-tense assertion of one insurer that "cancer. . . strikes one in every four Americans /emphasis added/" is almost certain to have this result.(34)

Since cancer insurance policies are commonly issued for a term of one year and less than 50% of cancer policies are kept for five years, let alone a lifetime, the estimated incidence of cancer for a single year might put the risk in better perspective: For 1979, the ACS estimates that one of every 280 Americans will contract cancer.(35) Without further interpretation, however, even this information could lead to an exaggerated notion of cancer risk.

To make an informed assessment, a consumer might want to know that the incidence of cancer varies greatly by age and community. Because some cancers are preventable, lower rates of incidence also apply to persons who avoid known causes of cancer, such as cigarette smoking; it is estimated that smoking alone accounts for 80% of all cases of lung cancer, or more than 10% of all cases of cancer.(36) In addition, a consumer might want to know that overall cancer-incidence estimates include many types of cancer, which are not all equally severe or costly. Colon cancer, for example, is highly curable (and therefore relatively less costly) if detected early; and colon cancer accounts for an estimated 15% of all new cancer cases.(37)

Belaboring cancer costs. The case for cancer insurance rests not only on the idea that cancer is a universal disease, but also on the idea that it generates very great medical expense. Along with fragmentary and rather frightening estimates of cancer incidence, therefore, most cancer insurance sales presentations contain equally stirring warnings about the high costs of cancer care.

American Income's agents state at the outset of their presentation that cancer and death are the two most crippling expenses any family can incur.(38) Later, with their notebook open to the pages reproduced previously on pages 12-14, the agents say:

> Medical societies tell us that one of the greatest threats of financial disaster due to disease is cancer. The cost is staggering. The astronomical cost of treatment is one of the problems we all face. It is not unusual for the cost of treatment to run somewhere between $30-40,000 and even more in many instances.(39)

The first page of the American Family brochure reproduced earlier on page 11 states that "CANCER IS GETTING MORE COSTLY" and then presents the nationwide cost of cancer treatment for the years 1962 and 1972. American Family agents tell sales prospects:

> Of course, you are aware that cancer is getting more expensive. It was estimated that in 1972, Americans would spend three billion on the cost of cancer. They actually spent 4.5 billion. The high cost of cancer is the reason I am here.(40)

Another American Family brochure poses the question, "Why do I need cancer insurance?" and answers the question in part by saying "cancer is often a lingering disease which requires repeated, extensive treatment and results in the victim's being unable to work."(41) In a 1978 article on cancer insurance, John Amos adds: "the average cancer will cost a patient more that $20,000 in hospitalization, radiation, drugs and doctor's bills, according to the American Cancer Society."(42)

A Union Fidelity brochure cautions that "the odds are very high that someone in your family will be stricken. . . so you must protect yourself and your family from the crushing costs."(43) Later on it refers to "the smothering costs of cancer." Accompanying the brochure is a statement from a family which says it learned of cancer insurance too late: "Now we have been struck with this horrible disease, and it has crippled us financially. The expenses are impossible to meet. It puts you in debt so far you can't even look ahead. We know!"(44)

Another brochure makes the same point under the heading "An Important Message" from Harry T. Dozer, chairman of Union Fidelity:

> There is a desperate need for cancer insurance to help finance treatment, which can run into months and years, and into thousands of dollars. . . The average person's financial resources are no match for this costly disease.(45)

A recent Union Fidelity direct mail letter to U.S. veterans reports that "this year Cancer will cost the American people over $3 billion, according to the American Cancer Society! That's almost as much as the entire Veterans Administration spent on Medical service in a recent year!"(46)

A Washington National brochure adds: "Improved treatment and better facilities cost more (over $5 billion in cost of treatment)."(47)

Like the statistical presentations used to demonstrate the high incidence of cancer, the company pronouncements on cancer costs are objectionable on several grounds. Adjectives like "crushing," "smothering," "staggering" and "astronomical" are obviously calculated to alarm without informing the consumer, and vague references to the possibility of bankruptcy for cancer victims likewise provide no quantifiable measure of the likelihood or extent of catastrophic loss.

Perhaps even more intimidating, but no more enlightening, are the statements that cancer costs from $3 billion to $5 billion annually or "almost as much the entire Veterans Administration spent on Medical service in a recent year!" Such aggregate cost estimates and comparisons supply a quantitative facade for the assertion that cancer is a costly disease, but still provide no useful frame of reference for an individual's decision whether to purchase cancer insurance.

The substantial inconsistencies in the aggregate estimates used by different insurers reflect the fact, which is not explained to consumers, that the few available technical studies of overall cancer costs employ varied methodologies and produce varied results.(48) At best, such estimates describe the societal costs of cancer; they tell nothing useful about the size and type of costs an individual family is likely to incur, or about the need for cancer policies to cover such costs.

The need for information on individual cancer costs seems superficially to be met by American Income's observation that "it is not unusual" for the costs of treatment to reach $30-40,000 or more, and by American Family Chairman Amos' statement that the "average" cancer will cost a patient $20,000 for medical treatment. Precisely because this information seems more plausible and useful for making a decision on cancer insurance, however, it must be severely faulted as both unsubstantiated and deceptive.

American Income's choice of the words "not unusual" to describe its uncorroborated estimate of $30-40,000 in treatment costs strongly implies that this amount is typical or average. This implication is simply false, as is indicated most immediately by American Family's use of a 50% lower $20,000 estimate for average treatment costs.

But American Family's estimate is also without apparent technical corroboration, and very probably is still too high. Although it is attributed to the American Cancer Society's 1979 Cancer Facts & Figures, this publication in turn cites the authority of a 1978 article in Consumer Reports, which cites no technical study or other basis for the statement.(49)

One widely quoted publication from which the $20,000 estimate might originally have been derived, a 1973 study by Cancer Care Inc. of the costs and consequences of catastrophic illness, concluded that the average total costs of cancer were "$21,718 per study family."(50)

Of its findings, however, this publication cautioned that "there is no claim that the findings from this sample are typical. . . of all cancer patients."(51) The study examined a small, non-random sample of 115 cancer patients who had received extensive assistance from the Cancer Care organization, who had advanced cancer, and who died of the disease. Moreover, the study's cost computations were based in many cases on family recollections rather than verified expense records. Only about 63% of the costs reported were for hospital, surgical and doctor expenses. The total average costs reported also included significant percentages of non-medical costs -- including "food for home help" and burial expenses -- which are not covered under either conventional health insurance or cancer insurance policies.

Belittling basic health insurance. Apart from issues of what is accurate and what is typical, the most fundamentally deceptive aspect of all expense estimates used by cancer insurers is that they steadfastly draw attention away from the single most important question about cancer treatment costs: To what extent are they likely to exceed the compensation available under an individual's basic health insurance policy?

Cancer costs covered under conventional health insurance cannot fairly or in any practical sense be characterized as a financial threat to cancer patients or their families, but cancer insurers energetically blur this central, if inconvenient, distinction. The cost presentations of cancer insurance selling materials generally feed the fear of "crushing" cancer costs by stating or implying -- falsely -- that a consumer's existing health insurance plan will not be a source of significant compensation for those costs.

Thus, American Income's sales presentation, after citing its bloated cost estimate of $30-40,000, concludes: "So, even with your health and welfare plan, you are still left with a whopping bill."(52)

Leaving out any reference to existing health insurance, the Union Fidelity brochure shown earlier on page 9 poses this false choice:

> YOU MUST MAKE A CHOICE. . .
>
> Either. . .
>
> 1. Take your chances and hope that cancer will not strike. . . or. . .
>
> 2. Give yourself and your family financial protection against the high costs of cancer /i.e., a Union Fidelity cancer policy/.

The American Family brochure reproduced earlier on page 11 also ignores existing health insurance. Another American Family brochure recognizes existing health insurance but minimizes its ability to cover the costs of cancer treatment:

> Health insurance may not cover all of your medical expenses and cancer has all the expenses of any illness, plus, in many cases, its own expensive requirements, for confinement, treatment, surgery, medication and other costs. . . This policy is intended to supplement your existing health insurance program to better provide for the unusual expense of cancer. . .(53)

If a consumer resists a sale by saying, "I have other insurance," or "I've got all the insurance that I need," or "I have a great hospitalization [plan]," American Family agents are taught to say in rebuttal the following statements, using "the statistics from the strike sheet as additional ammunition":

> I can appreciate you feeling that way, Mr. Jones, and most people feel the same; however, in reality we don't have ANY insurance. The doctor that treats you has insurance his bills will be paid. The hospital has insurance its bills will be paid. But, in reality, you do not have any insurance. You just pay the high premiums. Have you ever received any money from a hospitalization policy to put in your pocket? Mr. Jones, this is YOUR insurance. Should cancer strike any member of your family, we will pay our money directly to YOU and NOT to the doctors and hospitals.
>
> I'm glad to hear that, because nearly everyone that I enroll carries other insurance. . . and they enroll in this program to help take care of the hidden costs of cancer. . . such as travel expenses, loss of income, family care expenses, etc. . . and due to these hidden costs, most people feel that it is better to have a program like this and never need it, than to need it and not have it. I think so too.(54)

⋮

. Contrary to the statements and implications found throughout the marketing materials of cancer insurers, conventional health insurance policies held by at least three in four

Americans under age 65 cover many, and sometimes all, of the costs of cancer diagnosis and treatment.(55) Sales presentations that omit references to existing health insurance, or suggest that such policies provide insignificant coverage of cancer costs, are misleading in the extreme.

Also misleading are American Family's diversionary tactics -- when a sales prospect asserts he already has sufficient health insurance -- of denigrating that coverage because it may not provide "money. . . to put in your pocket." Providing pocket money is a dubious goal for a health insurance policy; American Family's statement that because existing insurance may pay doctors and hospitals directly, "in reality, you do not have any insurance. You just pay the high premiums" is false, malicious, and patently absurd.

The claim that cancer generates miscellaneous special costs, like loss of income and family care expenses, has more merit but is also true of other illnesses.(55a) Most cancer policies are designed to pay specific medical costs of cancer. They are not designed, nor are they approved by regulatory authorities, to provide disability benefits or to compensate other "hidden" cancer costs.

Cancer is a serious disease, its incidence is high and the costs of cancer care are high. However, by exaggerating the incidence and the costs for emotional effect, and omitting or distorting the facts about the extent of existing health insurance coverage, cancer insurance marketing materials and practices may be justly charged with "cashing in on fear."(56)

Another part of the cancer insurance marketing picture concerns the professed virtues of cancer insurance itself. Unfortunately, many of the most eye-catching claims in behalf of cancer insurance are open to the same criticism: that they succeed through exaggeration, distortion and the omission of facts consumers need for a rational purchase decision.

Promising Peace of Mind

Adept at graphically depicting the menace of dread disease, cancer insurers are also enthusiastic verbal artisans when it comes to promoting the merits of their product. Lest the bearers of bad news be blamed for their message, the typical cancer insurance sales presentation is carefully structured to go just far enough, and no further, in its grim recital of cancer risks. Then the focus of the story shifts to a proffered happy ending: the purchase of a cancer insurance policy. If the cancer threat is overblown, so also is the nature of the suggested remedy.

American Family's John Amos presents the most idealistic description of cancer insurance. "Above all else," he has said in advertisements appearing in several national periodicals, "our cancer policy provides to the insured Peace of Mind. Peace of mind that enough money will be available to fill the gaps -- to insure that he will never be a burden upon loved ones -- that life savings or plans for college education and a fair start in life for the coming generation -- will not be destroyed by a long and expensive battle with cancer."(57)

Expansive in their vision, alive more with intentions than with facts, Amos' rolling cadences suggest a function for cancer insurance at least as important as that of the New Deal, the Marshall Plan, or the current attempts to bring peace to the Middle East.

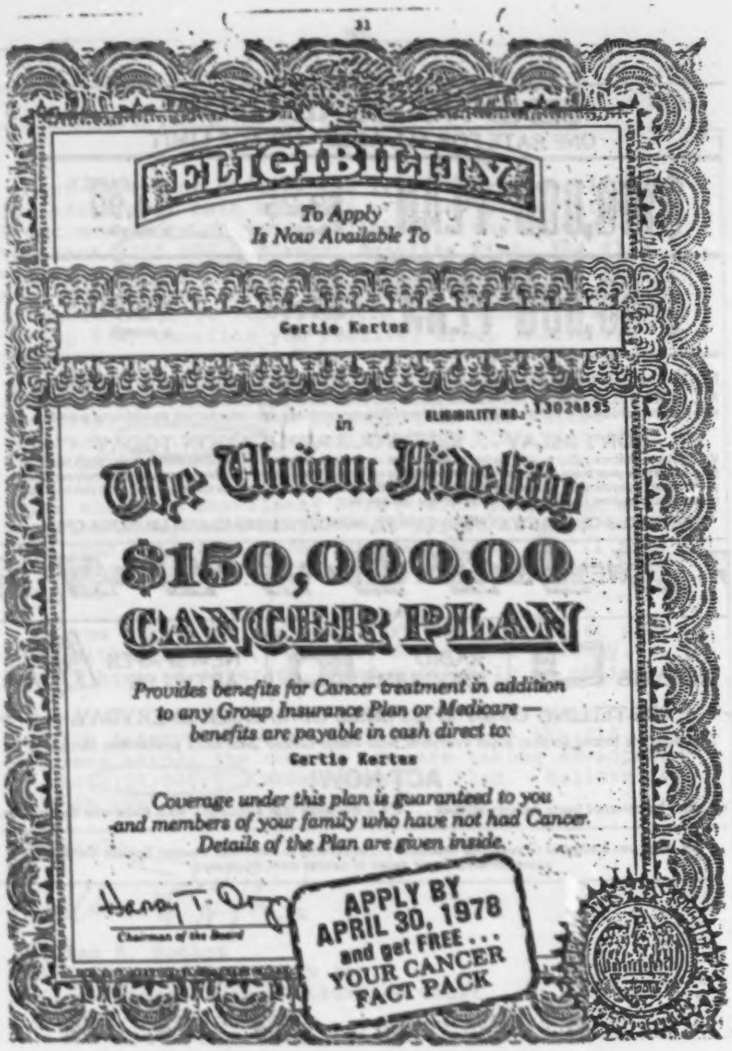
Of course, cancer insurance has no specific benefits for protecting life savings or plans for college education, much less a fair start in life for the coming generation. But Amos' description does astutely capitalize on the reality that many consumers can be induced to buy insurance as much for psychological security -- Peace of Mind -- as for the limited financial protection that it actually provides.

If one or more actual policy benefits can be made to sound concrete and plausible yet sweeping enough to support an equation with Peace of Mind, that feature will hardly hurt insurance sales. And in fact, most cancer insurers have learned to accentuate the positive and eliminate -- or gloss over -- the negative aspects of their coverage in ways skillfully designed to play upon a consumer's desire for Peace of Mind.

What could be more monumentally concrete, or more conducive to Peace of Mind, than a $250,000 cancer insurance policy? For the customers of Union Fidelity, Peace of Mind is available in $50,000 increments: The company markets a "$50,000 Plan," a "$100,000 Plan," a "$150,000 Plan," and a "$200,000 Plan." And recently, the company notified holders of the $200,000 Plan that they can increase their benefits "by a full 25%. . . NOW-$50,000 MORE CANCER COVERAGE FOR PENNIES A DAY PER PERSON!"(58)

By naming its policies to dramatize the maximum dollar benefits per person which each could possibly provide, Union Fidelity ingeniously quantifies the abstract essence of Peace of Mind, and implies a virtually inexhaustible source of financial protection against cancer.

Prominently displaying its six-figure policy names on elaborate "eligibility" certificates trimmed with fancy borders and a gold seal, and repeating them at every opportunity throughout its sales brochures and direct mail letters, the company promotes an overwhelmingly favorable impression of abundant benefits in light of which the specific terms and conditions of coverage are likely to seem mere footnotes — and much less important to read and understand. Three examples are shown on the following pages.(59)



31

ELIGIBILITY

To Apply
Is Now Available To

Gertie Kertes

in

ELIGIBILITY NO.: 13020895

The Union Fidelity

$150,000.00

CANCER PLAN

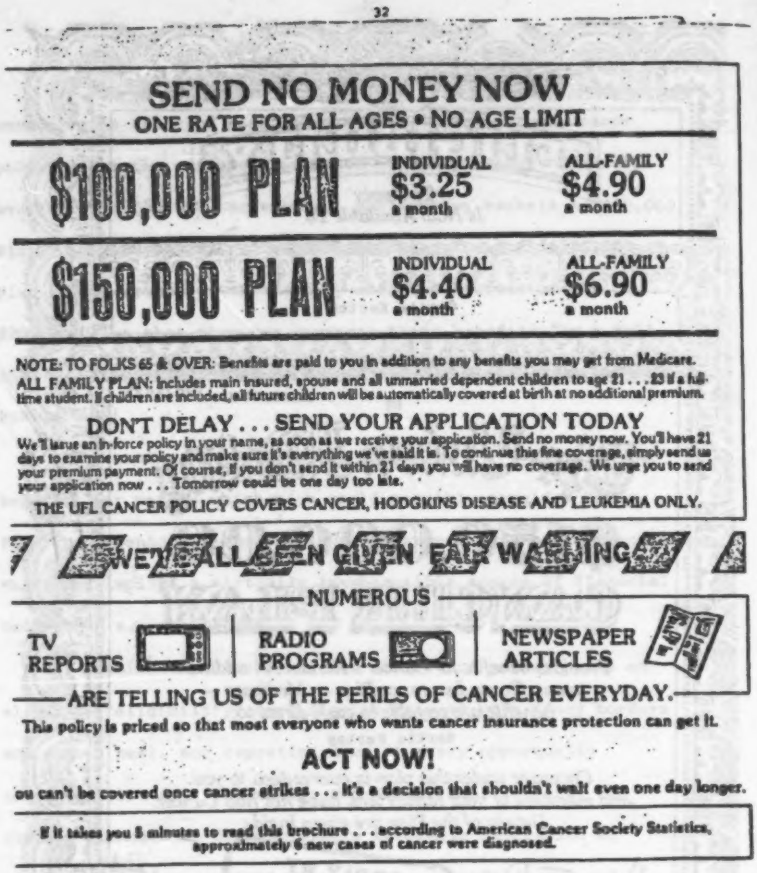
Provides benefits for Cancer treatment in addition to any Group Insurance Plan or Medicare — benefits are payable in cash direct to:

Gertie Kertes

Coverage under this plan is guaranteed to you and members of your family who have not had Cancer. Details of the Plan are given inside.

Harry T.
Chairman of the Board

APPLY BY
APRIL 30, 1978
and get FREE . . .
YOUR CANCER
FACT PACK



32

SEND NO MONEY NOW

ONE RATE FOR ALL AGES • NO AGE LIMIT

$100,000 PLAN INDIVIDUAL $3.25 a month ALL-FAMILY $4.90 a month

$150,000 PLAN INDIVIDUAL $4.40 a month ALL-FAMILY $6.90 a month

NOTE: TO FOLKS 65 & OVER: Benefits are paid to you in addition to any benefits you may get from Medicare.

ALL FAMILY PLAN: Includes main insured, spouse and all unmarried dependent children to age 21 . . . 23 if a full-time student. If children are included, all future children will be automatically covered at birth at no additional premium.

DON'T DELAY . . . SEND YOUR APPLICATION TODAY

We'll issue an in-force policy in your name, as soon as we receive your application. Send no money now. You'll have 21 days to examine your policy and make sure it's everything we've said it is. To continue this fine coverage, simply send us your premium payment. Of course, if you don't send it within 21 days you will have no coverage. We urge you to send your application now . . . Tomorrow could be one day too late.

THE UFL CANCER POLICY COVERS CANCER, HODGKINS DISEASE AND LEUKEMIA ONLY.

WE'VE ALL BEEN GIVEN FAIR WARNING

NUMEROUS

TV REPORTS | RADIO PROGRAMS | NEWSPAPER ARTICLES

ARE TELLING US OF THE PERILS OF CANCER EVERYDAY.

This policy is priced so that most everyone who wants cancer insurance protection can get it.

ACT NOW!

ou can't be covered once cancer strikes . . . it's a decision that shouldn't wait even one day longer.

If it takes you 5 minutes to read this brochure . . . according to American Cancer Society Statistics, approximately 6 new cases of cancer were diagnosed.

Most important of all, the Trust makes you eligible for additional cash benefits - at low group rates. Right now we've opened enrollment in the United Veterans $200,000.00 Cancer Benefits Plan. The Plan will pay you cash up to $200,000.00 for Cancer treatment both in and out of the hospital. And every penny is paid DIRECT TO YOU or anyone you choose in addition to any V.A. benefits you receive, Group Insurance, Medicare, or any other Plan.

Read the enclosed brochure. It spells out all your benefits, and shows how to enroll in the United Veterans $200,000.00 Cancer Benefits Plan...at LOW GROUP RATES.

The enclosed Enrollment Form - with your name and Veterans Acceptance number --is all we'll need to activate your coverage. SEND NO MONEY NOW. You'll have 21 days to examine the Plan FREE and decide if it is for you.

If you like what you see, just pay your first premium within 21 days. If not, don't send a penny. You'll have no coverage...and absolutely no obligation!

As a Vet, you gave your best to protect your country. Now YOU deserve the best in return. Join the U.S. Veterans across the country who are taking advantage of the $200,000.00 Cancer Benefits Plan. Believe me, it's in your best interest. Mail today!

Sincerely,

William R Hughes

William R. Hughes
Chief Petty Officer, USN Ret.
United Veterans Group Insurance Trust

Although no other company examined by the Division of Insurance puts as much emphasis on the total benefits available under a policy, all four cancer insurers tend to focus the consumer's attention on the upper reaches of cancer insurance protection. For example, American Income's agents -- while displaying the page from their notebook reproduced opposite -- describe an aggregate total of $35,640 in benefits and then add: "Now, I am not saying that in every case you will receive $35,000, but it is there for that long drawn out therapy."(60) This limited disclaimer undoubtedly does not deter the sales prospect from focusing on the total amount of potential benefits as a simple measure of the policy's worth.

Dissatisfied even with the standard line that one in four Americans will get cancer, American Income agents also point out the benefit bonanza available if four out of four contract the disease: "So, with four of you in the family, you will have a total of over $140,000 in scheduled benefits available to you."(61)

In most cancer insurance policies, it is something called "extended hospital benefits" that provides the foundation for promises of tens or even hundreds of thousands of dollars in benefits for cancer victims. The extended benefits provision pays 100% of hospital charges up to a specified monthly limit (usually $5,000) for continuous hospital stays in excess of 90 days.

COSTS

PAYS FULL BENEFITS REGARDLESS OF OTHER INSURANCE

YOU MAY OWN	MAXIMUM BENEFITS
HOSPITAL ($60.00/Day for Seven Days $30.00/Day thereafter)	$22,500.00
SURGICAL ($45.00 to $750.00 per operation as outlined in schedule of operations)	4,500.00
ANESTHESIA (Not to exceed $105.00 per operation)	1,050.00
X-RAY & RADIUM THERAPY, RADIOACTIVE ISOTOPES (Usual & Customary Charge)	1,500.00
NURSING ($36.00/Day when required)	750.00
ATTENDING PHYSICIAN, ($15.00/Day)	750.00
BLOOD PLASMA (Usual & Customary Charge)	450.00
AMBULANCE (Usual & Customary Charges)	150.00
TRANSPORTATION (Usual & Customary Charge)	750.00
	$32,400.00
PLUS 10% ON EACH VALID CLAIM	3,240.00
TOTAL	$35,640.00

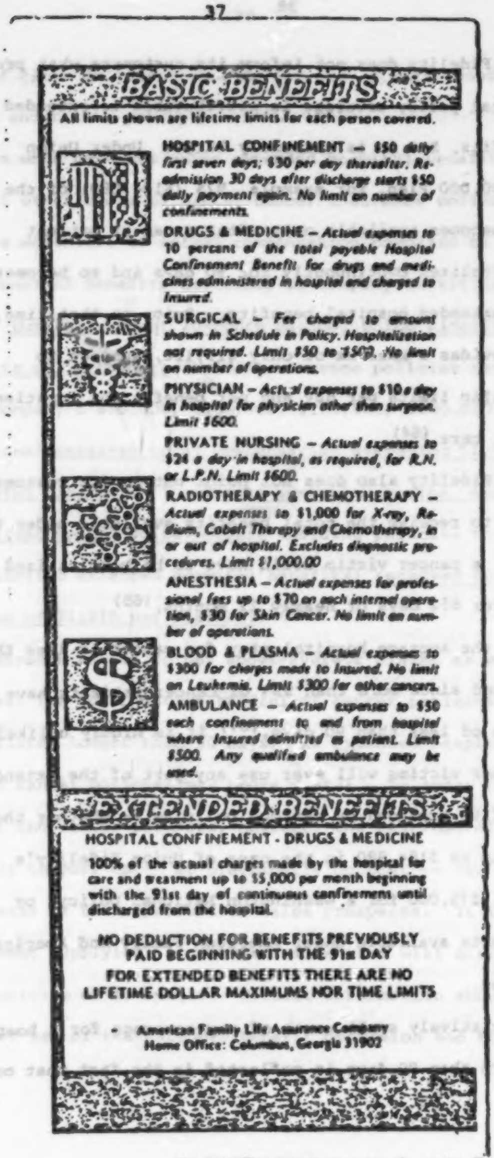
ANNUAL PREMIUM—Individual-$45.00 Family-$75.00 POLICY FEE-$5.00

Calling attention to this coverage, an American Family sales brochure graphically separates and highlights "EXTENDED BENEFITS" of up to $5,000 per month and adds: "FOR EXTENDED BENEFITS THERE ARE NO LIFETIME DOLLAR MAXIMUMS NOR TIME LIMITS." The brochure is reproduced on the next page.(62)

After describing basic benefits, American Family's agent sales presentation also explicitly cites the worth of extended benefits:

> Mr. Jones we feel all these benefits are great and I believe you agree. (Nod). However, our Company has gone one step further. As you know, cancer can sometimes become a lingering illness -- this doesn't always happen but it does happen. This is when the cost of cancer can bankrupt people -- cause them to go into their savings, borrow money to pay for their bills. Should you or a member of your family be confined to a hospital more than 90 days, beginning with the 91st day of confinement, our extended benefits will begin to pay 100 percent of the actual charges made by the hospital up to /$5,000/ per month. Mr. Jones, I believe you agree this one benefit could save you financial disaster. (Nod). And there are no lifetime dollar maximums nor time limits.(63)

American Income similarly offers an extended benefits provision covering costs of up to $6,000 per month with no lifetime limit, while Washington National provides extended hospital benefits of up to $5,100 per month to a maximum aggregate of $75,000.



BASIC BENEFITS

All limits shown are lifetime limits for each person covered.

HOSPITAL CONFINEMENT — *$50 daily first seven days; $30 per day thereafter. Readmission 30 days after discharge starts $50 daily payment again. No limit on number of confinements.*

DRUGS & MEDICINE — *Actual expenses to 10 percent of the total payable Hospital Confinement Benefit for drugs and medicines administered in hospital and charged to Insured.*

SURGICAL — *Fee charged to amount shown in Schedule in Policy. Hospitalization not required. Limit $50 to $500. No limit on number of operations.*

PHYSICIAN — *Actual expenses to $10 a day in hospital for physician other than surgeon. Limit $600.*

PRIVATE NURSING — *Actual expenses to $24 a day in hospital, as required, for R.N. or L.P.N. Limit $600.*

RADIOTHERAPY & CHEMOTHERAPY — *Actual expenses to $1,000 for X-ray, Radium, Cobalt Therapy and Chemotherapy, in or out of hospital. Excludes diagnostic procedures. Limit $1,000.00*

ANESTHESIA — *Actual expenses for professional fees up to $70 on each internal operation, $30 for Skin Cancer. No limit on number of operations.*

BLOOD & PLASMA — *Actual expenses to $300 for charges made to Insured. No limit on Leukemia. Limit $300 for other cancers.*

AMBULANCE — *Actual expenses to $50 each confinement to and from hospital where Insured admitted as patient. Limit $500. Any qualified ambulance may be used.*

EXTENDED BENEFITS

HOSPITAL CONFINEMENT - DRUGS & MEDICINE

100% of the actual charges made by the hospital for care and treatment up to $5,000 per month beginning with the 91st day of continuous confinement until discharged from the hospital.

NO DEDUCTION FOR BENEFITS PREVIOUSLY PAID BEGINNING WITH THE 91st DAY

FOR EXTENDED BENEFITS THERE ARE NO LIFETIME DOLLAR MAXIMUMS NOR TIME LIMITS

American Family Life Assurance Company
Home Office: Columbus, Georgia 31902

Union Fidelity does not inform its customers what proportion of total policy coverage is attributable to extended hospital benefits, but it is extremely large. Under Union Fidelity's $200,000 Plan, for example, 92% ($184,880) of the total amount becomes available only after a cancer patient has been hospitalized continuously for 90 days and so becomes eligible for extended hospital benefits. Prior to that time, the policy provides a maximum of only $15,120, subject to numerous specific limits per day and per benefit for inpatient and outpatient care.(64)

Union Fidelity also does not point out to its customers that in order to receive the total benefits available under the $200,000 Plan, a cancer victim would have to be hospitalized continuously for 652 days or nearly 22 months.(65)

Since the average hospital stay for cancer is less than 16 days,(66) and since more than 99% of cancer patients have hospital stays of less than 90 days,(67) it is highly unlikely that most cancer victims will ever use any part of the extended hospital benefits provided by various policies — whether the benefits add up to $184,880 in the case of Union Fidelity's $200,000 Plan, $75,000 for a Washington National policy, or unlimited amounts available under American Family and American Income policies.

The relatively small worth of any coverage for a hospitalization of more than 90 days is reflected in the fact that only about .1% of claim dollars -- one dollar out of each thousand -- is paid out under this policy provision.(68)

Even when payments under extended hospital benefits are added to all other claim payments, cancer insurance policies provide mere molehills of actual compensation compared to the mountain ranges of benefits described in company marketing materials. During a recent 20-month period, Union Fidelity's Massachusetts policyholders (holding assorted policies from among the company's $50,000, $100,000, $150,000, $200,000 and $250,000 Plans) received total compensation averaging $1,406 per successful claimant.(69) During a similar period, American Family's Massachusetts policyholders (holding policies that include unlimited extended hospital benefits) received total compensation of $1,278 per claimant.(70)

Insurance exists to pay above-average claims as well as average ones; for the relative handful of cancer patients who are hospitalized longer than 90 days, the extended hospital benefits of cancer policies may prove useful. To judge from the behavior of the cancer insurers, however, the main use of this provision is to puff up -- at practically no cost -- the attractiveness of their product to sales prospects. It is to imply, without supplying, a concrete value that will disarm the normal skepticism of consumers. Without information about the frequency of use of the extended benefit provision and the average claims actually paid under a policy, it is likely that most consumers receive an exaggerated, highly unrealistic impression of the practical performance of cancer insurance. And a very illusory foundation for Peace of Mind.(71)

Unfortunately, the illusion without the substance of sweeping cancer protection is also fostered by insufficient attention in marketing presentations to the significant gaps and limitations of cancer insurance coverage.

Finessing the Fine Print

In contrast to the dramatic accents in which they often present their version of policy benefits, cancer insurers also know how to be subtle, indirect and occasionally inscrutable in their discussion of policy limitations. Usually collapsed into a single paragraph away from the glare of large-type headlines, color ink and graphic displays lavished on policy benefits and cancer statistics, the list of limitations receives much less emphasis and explanation than it deserves.

Uncommonly restrictive "waiting periods," the restriction of benefits to "definitive cancer treatment," and the fundamental design of cancer insurance as supplemental -- and fragmentary -- coverage are among the important limitations of cancer policies that are systematically minimized or ignored in many marketing materials and sales presentations.

Waiting periods. Cancer insurance policies generally do not cover people with a previous medical history of cancer; such applicants are routinely screened out when they apply for coverage.(72) However, applicants with no prior cancer history who are accepted for coverage may also be destined never to receive benefits if they have the bad luck to receive a cancer diagnosis during a policy's "waiting period."

The significance of waiting periods may escape the notice of many applicants, because it is probably the least favorite revelation of cancer insurers. Sales prospects of American Family may never even hear the term waiting period, because the company's agents are instructed to use a circumlocution: "You are covered after [90] days participation in the plan." As American Family's training manual explains: "One thing a person never likes to hear is the term 'waiting period.' . . . It is felt that [the sentence used] is a nice, easy way to get around saying 'waiting period.'"(73)

A less nice, less easy, but still effective way to avoid the term waiting period is to substitute obtuse legal jargon. A Washington National brochure thus informs potential customers that

> (t)his insurance does not cover loss resulting from other than definitive treatment of cancer which first manifests itself and is first diagnosed prior to 30 days after the effective date of insurance.(74)

If this passage is confusing to the customer, it apparently confused the brochure writer as well. Intended to hint at the policy's 30-day waiting period, it actually says (erroneously) that cancer will not be covered unless it is diagnosed within 30 days after the policy takes effect.

Straightforward labeling would at least alert American Family and Washington National sales prospects to the possible importance of a waiting period. But the full significance of this provision can be confused even when straightforward terminology is used, as American Income demonstrates in its agent sales presentation. Admitting to a 120-day "waiting period" in its policy, the company rationalizes that this provision is typical of most health insurance policies:

> . . . any policy that pays for any type of medical treatment usually has a waiting period. That waiting period protects policyholders so that people will not enter the program knowing they already have conditions that require treatment. And, of course, the waiting period protects the company from the same thing. All of us would be hurt if this provision were not in the policy.(75)

Although American Income is most candid in using the term waiting period, it also makes the most explicitly deceptive statements about the nature of this provision. For the waiting periods under most cancer policies are not identical to the waiting periods usually found in other health insurance policies. That is why the failure to label them and point out their special significance can be so misleading to unwary consumers.

Contrary to American Income's assertion, the purpose of waiting periods in most health insurance policies is not to prevent the entry of people who know "they already have conditions that require treatment." When companies wish to prevent the entry of people with certain pre-existing illnesses, they can accomplish this by "underwriting" -- screening applications and rejecting applicants with prior diagnosis of the prescribed illnesses -- as cancer insurers now do in the case of pre-existing cancer.

As the name suggests, the purpose of a waiting period in most health insurance policies is only to specify a time that must pass before certain illnesses will be covered. If such an illness is diagnosed during the waiting period, there will be no coverage for the costs incurred during that time. But after the waiting period, further costs of the illness will be routinely paid under the policy.

Among the four insurers examined by the Division of Insurance, a cancer insurance waiting period is a different and far more restrictive provision. Unlike illnesses included under the waiting periods of most other policies, cancer diagnosed during this period is not merely excluded from coverage for the length of the waiting period; it is excluded from coverage altogether.(76)

If they desired, it would not be difficult for cancer insurers to effectively disclose to consumers the significance of their waiting periods. Despite its reluctance to do so publicly, American Family defines its provision simply and fairly effectively in its in-house Administrative Procedures Manual:

> Waiting period -- That period of time following the effective date during which, if cancer is diagnosed, no benefits will ever be due.(77)

A still more meaningful definition would be: "That period of months following the purchase of a cancer policy during which premiums are paid but no insurance is in force. Cancer diagnosed during this period will never be covered under the policy. Only cancer first diagnosed after this period will be covered."

Definitive cancer costs. Besides barring the costs of cancer first diagnosed during a policy's waiting period, cancer policies also bar the costs of anything other than "definitive cancer treatment." This sounds reasonable, but in fact means that there is no coverage for the costs of cancer diagnosis (even though, on account of the policy requirement that cancer be diagnosed pathologically, this ordinarily involves surgery).(78) It also means there is no coverage for the costs of health problems caused or complicated by cancer and cancer treatment. These can be significant costs to cancer victims, and are a significant part of the total cancer costs cited by insurers as an inducement to purchase cancer policies.

Despite the importance of this coverage limitation, two insurers -- Union Fidelity and American Income -- do not mention it in their marketing presentations. The other two companies -- American Family and Washington National -- say they will pay only for definitive cancer treatment. It is left to the sales prospect to discern that "treatment" is not the same as "diagnosis," and that "definitive cancer treatment" does not include the treatment of cancer-related health problems.

Supplemental coverage. The most serious omission from cancer insurance marketing presentations, finally, is that which ought to be the starting point for any reasonable analysis of its use and value: disclosure and adequate explanation of the intentionally supplementary (and therefore inherently limited, fragmentary) nature of cancer coverage. Without this disclosure, a consumer is not likely to understand the potential worth of either an existing basic insurance plan or a special cancer policy in meeting cancer costs.

People do not ordinarily insure illnesses separately, with one policy for appendicitis, another for heart attacks and a third for gall bladder operations. The sale of a separate policy for cancer implies the need for specialization, and specialization implies the need for intensive coverage. In the absence of any contrary indication, it would be reasonable for a buyer to assume that a cancer policy independently and exclusively provides adequate benefits to cover nearly all the costs so vividly portrayed in cancer insurance advertising.

Though plausible, this assumption is false. In making it, a sales prospect already having a good health insurance policy would overlook a valuable existing source of cancer coverage. A person without other health insurance would mistakenly assume a greater degree of protection than cancer insurance actually provides.

As John Amos originally conceived it, and as designed and marketed by nearly all insurers since then, cancer insurance is not intended to provide comprehensive coverage for even "definitive" cancer costs. Most of the benefits actually paid under cancer policies are for hospitalization of less than 90 days, and the largest scheduled benefits are usually for the first few days of a hospital stay. But hospital benefits of, for example, $60 per day for the first seven days and $30 per day thereafter are no match -- by themselves -- for the actual costs of hospital care.

If cancer policies have any claim at all to providing what Amos calls "enough money" for cancer victims, therefore, it is in the context of their limited function as supplemental coverage. Or to put the matter a different way: Even with cancer insurance protection, a consumer must rely primarily on ordinary health insurance to provide coverage for the high costs of cancer care. A rational analysis of the need for cancer protection would focus initially on the capacity of a consumer's existing basic or major medical policy to cover cancer costs, and then on the capacity of a supplement to fill the specific gaps, if any, in that coverage.

Consistent with their tactic of emphasizing cancer costs and ignoring or belittling the benefits provided by other health insurance, however, most cancer insurers avoid any indication -- certainly any adequate explanation -- that the whole purpose of their own product is indeed to supplement an existing health insurance policy. In their marketing presentations, three of the four cancer insurers examined by the Division of Insurance provide no explanation whatever of the supplemental nature of their policies. They inexcusably obscure the most elementary fact necessary for an understanding of cancer insurance.

An exception, American Family does label its cancer coverage as "supplemental" insurance in most of its policy brochures. Instead of explaining this term and focusing further light on the central question of how its policy might usefully coordinate with basic coverage, however, the company's agent presentation nimbly undercuts the "supplemental" label in its policy brochures.

As previously noted, American Family prospects who say they already have a good health insurance plan are boldly contradicted with the statement that they really "don't have ANY insurance." The agent then asks: "Have you ever received money from a hospitalization policy to put in your pocket?"(79) Adequate insurance, the company suggests, does put dollars into pockets; and the most attractive function of cancer insurance may be to duplicate rather than to supplement benefits received from other policies. Its own policy, American Family points out, "contains no provision reducing benefits because of Medicare or any group or individual insurance you may carry."(80)

American Family's characterization of its policy as a source of double recovery of cancer costs is probably more blatantly seductive than, and as misleading as, the marketing presentations of insurers that allow a consumer to believe cancer policies are the sole significant source of benefits for cancer costs.

The presentation is seductive because duplicate insurance payments, though attractive when viewed in isolation, contribute to the waste and inefficiency that make health care and health insurance costs a leading contributor to inflation and a pressing concern of families and government.

It is misleading because a consumer's other health insurance may have a "coordination-of-benefits" provision that will reduce its benefits when a covered service is paid for in whole or in part by American Family's cancer policy. Over 40% of Massachusetts residents have Blue Cross-Blue Shield policies with a coordination-of-benefits provison.(81)

By ignoring the effect of this provision in such policies, and by exploiting the illusory appeal of double recovery instead of explaining the true supplemental intent of its own coverage, American Family poses one more obstacle to a clear understanding of the strengths and limitations of cancer insurance.(82)

Together, the limitations of a cancer policy -- unusual waiting periods, the exclusion of non-definitive cancer costs, and the supplemental nature of its coverage, among others -- are the hard-edged boundaries that give size and shape to the vaunted list of policy benefits.

No one blames cancer insurance for having some limitations; all insurance policies do. It is the uncommon restrictiveness of some of these limitations -- and above all, the unexpected placement of so many holes, ditches and fences in a terrain where the billboards soothingly proclaim "Peace of Mind," "the $200,000 Plan," and unlimited extended benefits -- that make them so unfair.(83)

"The First Person Who Talks, Loses"

Although cancer insurers may believe in the universal appeal of their product, they appear to have even greater faith in the universal efficacy of the hard sell.

As has been seen, the typical cancer insurance selling presentation is not designed to sell a policy on its merits. It is not designed to give a consumer the balanced information that might permit a calm and rational decision on the possible need for supplemental coverage. It is designed, simply, to manipulate every sales prospect's perceptions so that he will make an instant and affirmative decision to buy a cancer policy.

The hard sell is calculated and systematic. In the selling presentations of the four companies examined by the Division of Insurance, almost nothing seems accidental or unplanned. Instead the typical selling presentation is an elaborately choreographed exercise in which nearly every step has been planned and rehearsed, every possible reaction of the consumer has been anticipated and prepared for, so as to carry the process forward to its one satisfactory conclusion: the closing of a sale.

From anxiety about cancer, to a vague longing for additional protection, to appreciation of effusively but incompletely described cancer coverage, the emotions and understanding of the prospect are carefully guided to the moment of signing an application. Building on the momentum of everything that has gone before, the closing itself is often artfully fashioned to focus maximum psychological pressure for the purpose of eliciting an immediate, positive response.

Agents of American Income lay the foundation for a successful closing at the outset of their presentation. Although they are instructed at sales meetings to make repeat calls as necessary,(84) the agents say to their union customers:

> The only thing I do ask is that you be in a position to make a decision this evening. Because of the tremendous number of people we have to call, on in your local and the others we are currently working with, it's just impossible for us to stop back. Fair enough? (get answer)(85)

If, after hearing the entire sales presentation, a family is still unconvinced about the need for cancer coverage and wants "to think it over," the agent begins a carefully structured closing argument that, in American Income's own words, "places the prospect in a position where he must make an instant decision."(86)

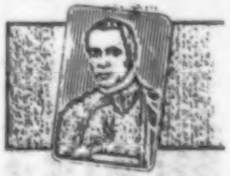
For companies like Union Fidelity that do not use agents, achieving an immediate response is more difficult but not impossible. One mail order brochure urges recipients to act immediately, lest cancer strike while they are still unprotected:

> ACT NOW: You can't be covered once cancer strikes. . . it's a decision that shouldn't wait even one day longer. If it takes you 5 minutes to read this brochure. . . according to American Cancer Society statistics approximately 6 new cases of cancer were diagnosed.(87)

To those needing further inducement, Union Fidelity has also offered several "free" gifts contingent upon the return of the policy application by a specified date. One gift, offered to Catholics, was a prayer plaque commemorating the canonization of Blessed John Neumann. Another was a "Cancer Fact Pack," described as a "frank report of Cancer's warning signs, plus lifesaving facts and information and How to Cope should Cancer Strike." Each gift was described on a separate flyer and frequently mentioned in the accompanying direct mail letters on cancer insurance. The flyers are reproduced on the next page.

As befits a company selling 60% of all cancer insurance, American Family has the most elaborate system for closing a sale successfully. In agent training presentations, the emphasis is on wearing the prospect down by quickly countering each objection that he raises. As explained in the company's training manual:

YOURS FREE IF YOU ACT BY JULY 22, 1977



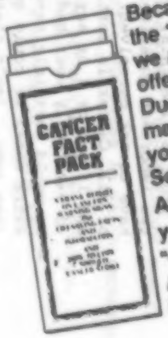
THIS METALLIC PRAYER PLAQUE COMMEMORATING THE CANNONIZATION OF THE BLESSED JOHN NEUMANN

Yours absolutely free if you act by July 22, 1977. Enroll in the United Catholic Group Insurance Trust now and receive this free gift you will want near you at all times. It's yours for the asking.

And how timely this gift is! June 19, 1977 is the date of the Cannonization of the first American male Saint . . . Blessed John Neumann. This metallic prayer plaque will be your personal reminder of the founder of the Catholic Education System in the United States.

FOR YOUR COMMEMORATIVE
PRAYER PLAQUE MAIL
BY JULY 22, 1977!

NOW... an extra month to get your "CANCER FACT PACK" absolutely free!



Because of the demand for the "Cancer Fact Pack" we are extending the offer to April 20, 1978. Due to this extension you may disregard the date on your eligibility certificate. So, if you apply before April 20, 1978, you'll still receive your "CANCER FACT PACK" Absolutely FREE! But don't delay. Apply now!

> An effective rebuttal system that you can use to great advantage is one that was first used years ago by the cookware industry. . . A simple way of expressing this method or system is:
>
> 1. Sweep the prospect off his feet.
> 2. Give a logical explanation.
> 3. Make a positive statement and ask an affirmative question.
> 4. Get an affirmative response.
> 5. Close and stay closed.(88)

An example of this system in operation is the rebuttal prepared for someone who wants additional time to think it over, or in the training manual's words, is "stalling":

> I can understand how you feel. However, you know in considering a program like this, there are two important questions that we have to ask ourselves. First of all, Cancer is costly. . . and if you or I or any member of our family ever had Cancer, we would certainly need all the extra money we could get and then some. Isn't that true? (Yes)
>
> Secondly, 21¢ a day isn't going to change our way of living in any way, shape or form. Isn't that true? (Yes)
>
> May I write it for you then?(89)

This rebuttal and others like it put the prospect on the defensive. The disconcerting effect is deliberately and aggressively pursued:

> . . . always have eye contact with your prospect. . . Always nod your head slightly when looking at the prospect. . . When closing, always move in towards the person you're selling. Never back away. The slightest backward movement can lose the sale. . . Even if it seems like he'll never answer just keep eye contact and nod your head slightly. Remember, the first person who talks, loses.(90)

The selling of cancer insurance is, after all, a business. If the whole selling process can be conducted and concluded with psychological techniques developed in the sale of cookware -- putting the consumer on the defensive and pressuring him for a decision before his carefully cultivated emotional responses have time to subside -- American Family apparently sees no reason to reject the opportunity.

Like all hard-sell businessmen, the dominant cancer insurers wage a continuing battle for sales in which technique, rather than product quality, is often the key to success. To the extent possible, it is a battle in which the winners -- and the losers -- have been determined in advance.

The genius of the industry's battle plan is that sales prospects are not merely outmaneuvered and outgunned; most hardly notice that the battle was done.

The burden of the plan is that, in the heat of battle, the thin line between enthusiasm and deception is often breached.

Conclusion

Cancer insurance was born in the quest of a gifted entrepreneur for "something else to sell" and nurtured on the widespread fear of cancer that makes every American a serious sales prospect.

Instead of demonstrating the "universal applicability" of their product, however, cancer insurers have demonstrated the perennial power of the hard sell. Instead of tailoring a sales presentation to the form of a generally useful insurance product, they have shaped an insurance product to the requirements of a generally successful sales campaign.

In that campaign, the unusual fear and vulnerability that many consumers feel in the face of cancer risk is routinely exploited for private gain. The Division of Insurance examination of four cancer insurers has documented a calculated, systematic pattern of selling in which cancer risks and costs are distorted or exaggerated; conventional health insurance is ignored or denigrated; and cancer insurance itself is appealingly but misleadingly described.

Such selling excesses are not merely violative of an elementary notion of fair play; they are also apparently violative of numerous statutory and regulatory provisions under Massachusetts law, as the Division's previously released market conduct audit reports have described in some detail.

As reported earlier in this chapter, a representative of the American Cancer Society once made a sensible observation about cancer insurance: "If such scare tactics. . . are necessary to sell a particular insurance policy," he said, "one must question why it can't be sold on its merits alone."

In addition to studying its characteristic selling methods, the Division of Insurance has also examined cancer insurance "on its merits alone." The results of that examination are presented in the following chapter.

II. THE PERFORMANCE OF CANCER INSURANCE

Twenty-one years have passed since John Amos invented cancer insurance, and in that time the product has performed amazingly well -- for American Family and other companies that sell it. By its own estimate accounting for only about 60% of all cancer insurance business, American Family achieved revenues of $300 million in 1978 and predicts a 33% growth, to $400 million, for 1979. American Family also achieved $36.7 million in profits for 1978; based on this performance, the 1979 compensation of Chairman Amos will total $918,000, not including dividends. By 1987, the company confidently expects to be earning more than $1 billion in annual revenues. If that goal is reached, under present contractual arrangements, Amos alone could be earning as much as $3.6 million in executive compensation in 1988.(1)

Excellent results for the sellers do not necessarily mean excellent results for those who buy and use the policy, however, and in this regard the performance of cancer insurance has been less than clear. Twenty-one years should be time enough to judge the performance of cancer insurance from the consumer's point of view, but the task is more difficult than first appears.

Chief among the obstacles to a clear understanding of the policy's performance for consumers has been the deliberate obfuscation of the grounds on which that performance should be judged. In their advertising and selling presentations, as seen in the preceding chapter, cancer insurers consistently ignore or denigrate conventional health insurance and suggest that their product is both a necessary and a major source of cancer protection, abundantly pouring forth everything from "peace of mind" to tens or even hundreds of thousands of dollars in benefits. But in explaining to state insurance regulators the actual performance of cancer coverage -- including average claim payments of "between $1,000 and $2,000" -- the companies are far more modest and circumspect. When facing informed and authoritative scrutiny, the insurers are only too happy to insist that their product is, after all, only "low cost supplementary insurance" and should be judged accordingly.(2)

Whether cancer insurance should be judged by the grand pretensions of its selling presentations or only on the narrower ground of its actual design and intent, a further problem is that consumers are uniquely disadvantaged in judging cancer policies on any grounds at all.

While cancer insurers can command batteries of lawyers, accountants and computer experts to tally up their sales and profits, consumers must rely on much simpler devices to judge how a cancer policy is likely to perform for them. In this undertaking they are dependent for information on company sales presentations that -- as has been seen -- often substitute an emotional appeal for a rational analysis of need, and sweeping assurances for balanced and detailed facts about cancer coverage. The cancer policy itself provides more detailed information, but is not usually available until after the sale; like other insurance policies, it may not be the easiest document to read and understand.

For the individual consumer, the ultimate test of any policy comes at claim time; it is then that expectations and actual performance can be definitively compared. Because of the specialized nature of cancer coverage, however, most cancer insurance policyholders are likely -- quite fortunately -- never to have occasion to put their policies to this acid test.

For the perhaps one in eight insureds who eventually contract cancer and file a claim, moreover, it may still be quite difficult to accurately assess the performance of their cancer policies.(3) The reason is that, contrary to the impression so assiduously created by cancer insurance marketing, the great majority of consumers have an underlying layer of broad health insurance coverage that will in fact be a substantial resource for meeting cancer costs.

If this conventional health insurance policy performs even moderately well, it will relieve the consumer's cancer policy of any necessity to deliver on its claim to be a major source of cancer compensation. If the conventional policy provides broad cancer coverage -- as many do -- it will relieve the cancer policy of any serious pressure to perform effectively even as a supplement. In either of these cases, the consumer's acid test will be of two policies acting collectively to cover cancer costs, and the individual responsibility and performance of each policy will be more difficult to unravel and to judge.

In the end, of course, the performance of an insurance policy cannot be wholly known to a consumer acting solely on his own information and experience, even if the policy is free of the special obstacles to rational analysis posed by cancer insurance. For the performance of a policy is more than a series of isolated transactions between individual claimants and an insurance company: It is an intricate tapestry woven from the individual and collective experiences of many policyholders over many years.

To understand and evaluate the overall performance of cancer insurance, it is desirable to answer a number of questions:

-- What, specifically, will the policy cover and what will it not?

-- How large a benefit will the policy pay, on average?

-- How much of the premium dollar will go to benefits, and how much to insurers' expenses and profits?

-- How general is the need for a cancer supplement? How good a supplement is a cancer policy? Could another policy do a better job?

The answers to these questions must be sought in many places. The realities of policy performance can be glimpsed in part in the insurers' selling presentations, and in part in the language of their policy forms. In even greater part, however, they must be sought in complex company statistics -- often unsorted and uninterpreted -- on selling expenses and claim payments; in other complex statistics, more likely to be collected by health care researches than insurance companies, on the actual patterns and costs of cancer treatment; and in analysis, more likely to be undertaken by insurance regulators than insurance companies, of the relative merits of different policies, and types of policies, in meeting consumer needs.

The diversity of information sources necessary to analyze the actual performance of cancer insurance suggests that it is not a simple task, even for a cancer insurer or a state regulator. As a direct result of their own selling methods, however, cancer insurers have motivated millions of consumers to invest hundreds of millions of dollars in premiums, and an even larger measure of hope, in the policies that they sell. Simple task or not, an adequate assessment of cancer insurance is necessary to inform consumers whether the product in fact deserves this confidence, whether it will perform at least as well for them as it does for those who sell it.

As part of its comprehensive examination of four cancer insurers, the Division of Insurance has attempted to trace the diverse threads of cancer insurance performance, and to observe the patterns that they weave. Against the backdrop of sweeping selling claims, the Division has traced product limitations that do not fulfill even the most modest expectations a consumer might apply to any insurance policy. Against the narrower, specific claim of cancer coverage to be a valuable insurance supplement, narrower and more specific defects have been revealed.

Benefits, Limitations and Claim Payments

"Insurance is like a sieve," a cancer insurance executive once said. "The first thing that drops out is a deductible and 20 percent of the cost. Then there are exclusions and limits. When you get down to it, you've got about 50 percent you've got to pay yourself." (4)

The executive was describing conventional health insurance and, as cancer insurers often do, exaggerating its defects. Most conventional health insurance plans pay much more than 50% of health care costs, including those for cancer.(5)

But the analogy is apt. Any insurance policy has both benefits and limitations, things it will pay for and things it won't. Like a sieve, the policy catches some costs and "drops out" others. And cancer insurance, it should be noted, is a very leaky sieve.

Consumers do not ordinarily take to leaky insurance policies, any more than to leaky boats. But most consumers purchase policies on the basis of impressions gained from sales presentations, and cancer insurance selling -- as has been seen -- skillfully glosses over its own defects.

The cancer insurance policy. The language of the cancer insurance policy, typically received by the consumer a short time after applying for coverage, offers a second chance to learn about important benefits and limitations. The policy is the definitive expression of the promises a cancer insurer makes to its insureds. It is more detailed than a selling presentation, and theoretically provides the means to learn much more about how the product will perform.

In practice, however, cancer insurance policies are effectively designed to do through over-complication what the selling presentations do through over-simplification: simultaneously to exaggerate and obfuscate the real performance of cancer coverage.

In the writing of insurance policies, insurance companies generally have long displayed the ability to transform detail and precision from a virtue into a vice. Cancer insurers are no exception to this rule. The policy forms of all four cancer insurers examined by the Division of Insurance contain passages that are as useful for confusing consumers as for enlightening them. The first sentence of Part 1 of an American Income cancer policy is a case in point:

> Only if any insured shall become afflicted with cancer, which is first diagnosed, as herein defined in Part 2, in the entire lifetime of the insured on or after the 120th day following the policy date shown on Page 4 and while this policy is in force and such sickness is diagnosed as provided herein, the company will pay indemnities according to the Schedule of Benefits, as shown on Page 2, for the

> expenses incurred by the Insured, except
> as otherwise provided herein, with a
> period of time beginning not more than
> 10 days preceding the date of which
> positive diagnosis as herein defined is
> made and within three years from such
> date for cancer or malignant tumor(s)
> originating in a given organ or body
> system, but in no case shall more than
> the maximum benefits, as shown on Page 2,
> for each service or benefit be paid with
> respect to any one insured, irrespective
> of the number of cancers or malignant
> tumors experienced by said insured.(6)

The use of a 167-word opening sentence is a wonderfully ironic way of telling consumers very little while seeming to tell them a lot. It is, however, an example of a "readability" problem that can be remedied fairly easily by shortening sentences and straightening garbled syntax. A new Massachusetts law requiring that all insurance policies be rewritten to meet minimum readability standards should result in at least this degree of improvement in cancer policies by late 1979.(7)

But the real genius of cancer policies -- their ability to suggest broad coverage while providing at every turn for the narrowing of benefit payments -- is a constitutional trait that runs much deeper than policy language. It inheres in the basic design of policy benefits and limitations and could easily survive, more formidable than ever, after cosmetic improvements in sentences and words.

Typical product design. The basic design of cancer insurance benefits and limitations can be analyzed most easily when it is abstracted from the contorted policy language in which it currently appears. Table 1 summarizes and compares the benefits and limitations

Comparison of Six Cancer Policies

Company	American Family Life Assurance Company of Columbus, Georgia		American Income Life Insurance Company		Union Fidelity Life Insurance Company	Washington National Life Insurance Co.
Policy Number	A-6883	A-3811	CAN (B73) with rider PS-100	CNR (1174)	I-3100-32	AR 1090C
Benefits						
1. Hospital Confinement	$50 per day for the first 7 days, $30 per day for next 83 days; Usual and Customary hospital charges up to $5000 per month ($167 per day) thereafter	$100 per day for the first 90 days; $200 per day thereafter	$60 per day for the first 7 days, $30 per day thereafter; maximum of $22,500	$50 per day for the first 7 days, $30 per day for next 83 days; u and c hospital charges up to $5000 per month ($167 per day) thereafter	$60 per day for the first 7 days, $40 per day for next 83 days; u and c hospital charges up to $5000 per month ($167 per day) thereafter	$60 per day for the first 13 days, $30 per day for next 76 days; u and c hospital charges up to $5100 per month ($170 per day) thereafter
2. Drugs and Medicines	Actual hospital charges up to 10% of hospital benefit for confinements not over 90 days	None	None	Actual hospital charges up to 10% of hospital benefit for confinements not over 90 days	Actual hospital charges up to 10% of hospital benefit for confinements not over 90 days, maximum of $810	Actual hospital charges up to 10% of hospital benefit for confinements not over 90 days
3. Surgical	Actual charges up to amounts specified in schedule of operations, ranging from $50 to $900 per operation	None	Actual charges up to amounts specified in schedule of operations, ranging from $45 to $750; lifetime maximum of $4500	Actual charges up to amounts specified in schedule of operations, ranging from $30 to $600	Actual charges up to amounts specified in schedule of operations, ranging from $30 to $900	U and c charges up to amounts specified in schedule of operations ranging from $50 to $800
4. Attending Physician, In-hospital	Actual charges up to $10 per day; maximum of $600	None	Actual charges up to $15 per day; maximum of $750	Actual charges up to $10 per day; maximum of $600	Actual charges up to $10 per day; maximum of $600	Actual charges up to $10 per day; maximum of $900
5. Private Duty Nurse, In-hospital	Actual charges up to $24 per day; maximum of $600	None	Actual charges up to $36 per day; maximum of $750	Actual charges up to $24 per day; maximum of $600	Actual charges up to $24 per day; maximum of $600	U and c charges up to $24 per day; maximum of $1000
6. Radiation Therapy	U and c charges up to $1000 combined maximum with chemotherapy	None	U and c charges up to $1500	U and c charges up to $1100	Actual charges up to $1000	U and c charges up to $1500
7. Chemotherapy	U and c charges up to $1000 combined maximum with radiation therapy	None	None	None	None	None
8. Anesthesia	Actual charges up to $70 per internal operation and $30 per skin operation	None	Actual charges up to $105 per internal operation and $45 per skin operation; maximum of $1050	Actual charges up to $70 per internal operation and $30 per skin operation	Actual charges up to $70 per internal operation and $30 per skin operation	U and c charges up to $125 per internal operation and $30 per skin operation
9. Blood and Plasma	U and c charges up to $300 with no limit for leukemia	None	U and c charges up to $450	U and c charges up to $350 with no limit for leukemia	Actual charges up to $300 with no limit for leukemia	U and c charges up to $500

10. Ambulance	U and c charges up to $50 per hospital confinement; maximum of $500	None	U and c charges up to $150	U and c charges up to $50 per hospital confinement; maximum of $500	Actual charges up to $50 per hospital confinement; maximum of $500	U and c charges up to $50 per hospital confinement; maximum of $500
11. Transportation	None	None	U and c charges up to $750 for air or mail travel to the nearest hospital that provides a special treatment that cannot be obtained locally	U and c charges up to $550 for air or mail travel to the nearest hospital that provides a special treatment that cannot be obtained locally	None	None
General Provisions						
1. Coverage Limits	None	None	$32,400 (sum of internal limits); no benefits paid after 3 years from date of diagnosis	No benefits paid after 5 years from date of diagnosis	$100,000; no benefits paid after 3 years from date of diagnosis	$75,000
2. Pre-Existing Cancer	Diagnosed cancer excluded	Diagnosed cancer excluded	Diagnosed cancer excluded	Medically treated or diagnosed cancer excluded	Diagnosed cancer excluded	Diagnosed cancer excluded
3. Waiting Period	Cancer diagnosed during first 99 days of policy excluded	Cancer diagnosed during first 60 days of policy excluded	Cancer diagnosed during first 119 days of policy excluded	Cancer medically treated or diagnosed during first 89 days of policy excluded	Cancer diagnosed during first 119 days of policy excluded	Cancer diagnosed during first 29 days of policy excluded
4. Retroactive payment for treatment prior to date of pathological diagnosis	Payment up to 10 days prior to diagnosis; if diagnosis can only be made post-mortem, payment for final admission of up to 45 days	Payment up to 30 days prior to diagnosis; if diagnosis can only be made post-mortem, payment for final admission of up to 45 days	Payment up to 10 days prior to diagnosis; if diagnosis can only be made post-mortem, payment for final admission of up to 45 days	Payment up to 10 days days prior to diagnosis; if diagnosis can only be made post-mortem, payment for final admission of up to 45 days	Payment up to 10 days prior to diagnosis; if diagnosis can only be made post-mortem, payment for final admission of up to 45 days	Payment (a) to beginning of hospital confinement during which diagnosis is made or (b) up to 10 days prior to diagnosis, whichever is more favorable to insured
5. Renewability	Renewable by insured for life; premiums may be changed by class	Renewable by insured for life; premiums may be changed by class	Renewable by insured for life; premiums may be changed by class	Renewable by insured for life; premiums may be changed by class	Renewable by insured for life; premiums may be changed by class	Renewable by insured for life provided master (group) policy in force and insured remains member of group; premiums may be changed
6. Annual Premiums						
Individual	$40 ($30 for employee group sales)	$50 ($42 for employee group sales)	$45 ($33 for employee group sales)	$60 ($39.40 for employee group sales)	$39	$34
Family	$60 ($45 for employee group sales)	$75 ($57 for employee group sales)	$75 ($54 for employee group sales)	$60 ($44.00 for employee group sales)	$90.00	$65
		This policy with rider PI-179 provides two-thirds of each benefit and costs $30 and $50; the policy without the rider provides one-third of each benefit and costs $15 and $25			The "$150,000 Plan" increases all benefits by one half and costs $52.80 and $82.80; the "200,000 Plan" doubles all benefits and costs $75 and $114	

Table 2

Typical Cancer Insurance Policy

Benefits: (ranked in order of estimated amounts of total claims paid under each benefit)

1. First 7 days of hospital confinement- $60 per day.
2. Next 83 days of continuous hospital confinement - $30 per day.
3. Surgery, in-hospital and out-of-hospital - actual expenses up to the maximum stated in a schedule of operations, ranging from $50 (amputation of finger) to $600 (complete removal of brain cancer); corresponding amounts up to $600 paid for procedures not listed.
4. Radiation therapy, in-hospital and out-of-hospital - actual expenses up to a $1000 lifetime limit for cancer treatment that utilizes x-rays, radium, cobalt, and other radioisotopes to destroy cancerous tissue.
5. Attendance in hospital by physician other than surgeon - actual charges up to $10 per day; $600 lifetime maximum.
6. Drugs and medicines administered in hospital - actual expenses up to 10% of benefit paid under (1) and (2). Not paid once hospital stay exceeds 90 days and payments start under (11).
7. Anesthesia, in-hospital and out-of-hospital - actual expenses of anesthesiologist up to $70 for each internal operation and $30 for each skin cancer operation.
8. Private duty nursing in hospital - actual charges up to $24 per day; $600 lifetime maximum.
9. Blood and plasma - actual expenses up to $300 lifetime limit, no limit for leukemia.
10. Ambulance to and from hospital - actual expenses up to $50 per confinement; $500 lifetime maximum.
11. Extended in-hospital benefits - usual and customary hospital charges up to $5000 per month ($167 per day).

General Provisions and Limitations:

1. Pre-existing condition exclusion - no benefits paid for cancer diagnosed prior to effective date of policy.
2. Waiting period - no benefits ever paid for cancer diagnosed during first 90 days of policy.
3. Cancer must be diagnosed pathologically; clinical diagnosis not accepted.
4. Benefits restricted to "definitive cancer treatment" - no benefits paid for diagnostic, rehabilitative or follow-up costs, or for conditions caused or complicated by cancer or cancer treatment.
5. Retroactive benefits paid up to 10 days prior to pathological diagnosis.
6. Retroactive benefits paid up to 45 days prior to post-mortem pathological diagnosis, provided pathological diagnosis not possible during life.
7. Renewable by insured for life though premium may be changed by class.
8. Annual premium payment - $40 for an individual, $60 for a family.

of six cancer policies. They are the principal offerings in Massachusetts of the four cancer insurers examined by the Division of Insurance, and are identical or similar to policies that the same companies also sell in other states.(8)

As Table 1 shows, most cancer insurance policies issued by different insurers share a common design, and are similar even in specific coverage provisions. This reflects the long dominance of American Family in the cancer insurance market, and the fact that most policies have been copied or adapted from American Family's policy form A-6021. The most widely sold cancer policy in the country, Form A-6021 is also the model for a national standard cancer plan developed by an actuarial consulting firm for estimating reserves for future claims on cancer policies.(9)

Because of the similarity among policies and the dominant market share of the issuing companies, the information in Table 1 can be used to form a picture of the "typical" Massachusetts cancer insurance policy. The principal benefits and limitations of the typical policy are summarized in Table 2. In view of the substantial uniformity among cancer insurance policies nationwide, Table 2 may also be regarded as a picture of the typical U.S. cancer policy.(10)

Illusory benefits. At first glance, the long list of numerous specific benefits is conducive to the feeling of well-being and security that cancer insurers strive always to impart. The benefits are all different, and perhaps too complicated to remember either as individual items or in the pattern of coverage they form, but there is certainly the appearance of protection that is extensive and carefully planned.

On closer examination, it may be more clearly discerned that every cancer insurance benefit provision is simultaneously an act of giving and an act of taking away. Useful for suggesting broad and varied coverage, the cancer policy's separate listing of numerous specific benefits also creates the opportunity to impose separate benefit "limits" that are specific and severe.

The typical policy pays for private duty nursing in the hospital, for example, but only to a limit of $24 per day with a lifetime limit of $600. The typical policy covers radiation therapy in or out of the hospital, but only "up to" a lifetime limit of $1,000. The policy pays for hospital room and board, but only to a limit of $60 per day for the first seven days and $30 per day for the next 83 days.

Even the policy's vaunted "extended benefits" for continuous hospital stays over 90 days (which, as seen in the last chapter, form the basis for sales representations of tens or hundreds of thousand of dollars in available benefits, although they actually account for only one in every 1,000 dollars of claim payments) have a typical monthly benefit limit of $5,000 -- and a less obvious but equally real limit of $167 per day for hospital costs.

Under cover of describing generous and flexible benefits for policyholders, the typical cancer policy thus inconspicuously establishes the necessary mechanism for delivering compensation that is in reality neither generous nor flexible.

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Although repeated statements that the policy pays actual expenses for medical services "up to" the specified limits might suggest to some consumers that the limits are above current prevailing charges for such services, most benefit limits are below the actual costs of cancer victims.

The limits rapidly become even less adequate due to the high rate of inflation in medical costs.

And the rigid compartmentalization of coverage effected by the limits on every separate benefit means that compensation cannot be flexibly shifted from one area of costs to another in accord with the varying needs of individual cancer patients.

Unobtrusive limitations. Although dollar limits on individual benefits substantially restrict the compensation available from cancer insurance, they are not the only tools the typical policy uses to narrow and limit its responsibility for cancer costs.

Scattered throughout the policy under a diversity of headings are a number of other limitations, even less obtrusive but no less effective, for restricting payments to cancer victims. These include the "waiting period" for eligibility to receive cancer insurance protection, already discussed in the previous chapter in connection with sales presentations; time limits on the availability of coverage after cancer diagnosis; the requirement of a pathological diagnosis of cancer; and the numerous less-than-obvious ramifications of the restriction of benefits to definitive cancer treatment.

Three of the six cancer policies reviewed by the Division of Insurance will pay benefits only within a specified time limit -- usually three years -- after the date of cancer diagnosis. Although three years may seem an adequate time in which to treat cancer, a number of cancers involve treatment of longer duration. This may be inferred from median survival times, which represent the length of time after cancer diagnosis when half the patients have died and half are still alive.

For breast cancer, for example, the median survival time is six years and seven months.(11) Of the 50% of patients who die within this time, a sizeable number undoubtedly die after three years from the date of diagnosis, and if they had cancer insurance, they would not have had their treatment before death covered. The 50% of patients who live longer than the median survival time would face an even longer period of potential costs without the continuing protection of cancer insurance benefits.

The typical cancer policy pays benefits only if cancer is diagnosed pathologically; clinical diagnosis is not acceptable. This distinction may seem of little consequence, but it is not without serious problems, as noted by one physician writing to protest the denial of his patient's claim:

> We therefore felt he has clinical evidence of lung cancer with a brain metastases. . . if he succumbs, we will get [a pathological report] in autopsy and if his condition goes on to further deterioration we then can perhaps operate and get a tissue diagnosis to prove it, but I would consider this unnecessary surgery.(12)

For a variety of reasons having to do with the age and health of the patient and the type of cancer involved, a pathological diagnosis is not always medically necessary, desirable, or possible. Lung cancer and brain cancer are two types of the disease in which cytological washings, CAT scanning and other diagnostic procedures are often used as a substitute for the surgical removal of a tissue sample.(13)

The typical cancer policy covers only "definitive cancer treatment." On its face, this may not seem to be of concern to the policyholder. However, this is a highly restrictive provision, and its consequences are not spelled out in the policy. One consequence is that limiting payments to cancer treatment necessarily precludes payments for diagnostic hospital admissions and procedures, including the required pathologist's report, the cost of which may be significant. In 1970, the 10% of cancer patients whose first hospital admission involved only a biopsy -- and therefore no "definitive treatment" -- paid on average $1,000 ($1,800 in today's dollars) to the hospital alone.(14)

Most cancer policies have clauses that do provide retroactive benefits for up to 10 days of hospitalization prior to the required pathological diagnosis, and up to 45 days in the event of death. Although it might be thought that these provisions would result in coverage of all expenses during the specified period before pathological diagnosis, in such circumstances the policy still covers only those costs related to cancer treatment. Diagnostic costs remain unpaid.

Another important consequence of the treatment-only limitation, also not explained in the policy, is that rehabilitation from the effects of cancer is not considered treatment and therefore is not covered. For example, one Massachusetts woman was denied benefits for surgery to remove scar tissue caused by initial cancer surgery. Although her doctor certified that the operation was necessitated by and was a continuation of the initial treatment, the cancer insurer offered this rather tortured explanation of the reason its coverage did not apply:

> The treatment was in regard to previous breast surgery. The breast surgery was for cancer, and that claim was paid. However, since the second treatment was the result of the scar tissue, rather than the direct result of cancer, no benefits have been paid. (15)

A treatment-only limitation also means there is no coverage for post-treatment hospital admissions to check for the recurrence of cancer. A Massachusetts man with a bladder tumor was denied hospital benefits for each follow-up cytoscopy that showed the cancer had not recurred. The man's physician denounced the payment restriction as unreasonable and deceptive:

> It is clear that all these hospital addmissions were related to a cancer condition of the bladder. If [the cancer insurer] sells a policy which provides hospital benefits for cancer that is positively diagnosed on the

> basis of microscopic examination, I should think that this was a condition which should qualify. If they deny coverage on the basis that no tumor was found on those two particular short-term admissions, then it seems to me that the sale of this policy is deceptive to say the least.(16)

Besides excluding diagnostic and follow-up costs, the restriction of cancer insurance benefits to definitive cancer treatment also means that no payments will be made for illness or disease caused or complicated by cancer or cancer treatment. Three of the six policies reviewed by the Division of Insurance fail to mention this specific effect of the definitive treatment provision at all, and even the remaining three do not sufficiently explain how it is applied.(17) Few consumers might expect, for example, that hospitalization for a broken leg directly resulting from its brittleness due to cobalt treatments for cancer would not be covered under a cancer policy; and yet that is the case.

Average claim payments. It is conventional health insurance, rather than his own product, that a prominent cancer insurer has described as a "sieve" dropping out substantial health care costs instead of paying them.

Yet no insurance policy functions more truly like a sieve than cancer coverage. Subtly, unobtrusively, but systematically and effectively, the myriad limitations of cancer insurance riddle the policy with holes that drop out about 70% of cancer costs.

leaving them to be paid by the cancer victim -- or his conventional health insurance plan.(18)

Despite its expansive promises of "peace of mind" for cancer victims, American Family paid total benefits averaging only $1,278 per successful claimant during the 18-month period between January 1, 1977 and June 30, 1978.(19)

Despite policies called "the $200,000 Plan" and "the $150,000 Plan," Union Fidelity paid benefits averaging only $1,406 per claimant during a similar period.(20)

Despite stern warnings of "staggering. . .astronomical" cancer costs running to "between $30-40,000" per cancer victim, American Income's average claim payment totaled only $1,396 during a comparable time.(21)

Creative in exploiting the fears and winning the confidence of consumers regarding a way to fill the need for cancer compensation, cancer insurers are, however, more resourceful in finding the means to reject or reduce cancer claims than in finding the willingness or the ability to pay them.

Benefit-to-Premium Ratios

When confronted with the gap between their modest average benefit payments and the sweeping assurances of their sales presentations, cancer insurers are likely to defend themselves by emphasizing the low cost and the limited supplemental function of their coverage. "When viewed as low cost, supplementary insurance, as it should be," says a consulting actuary retained by American Family, "the arguments that it is improperly designed for good value fall down and turn into arbitrary opinion."(22)

Of course, cancer insurers cannot escape responsibility for the extravagant expectations promoted through their sales presentations by asserting, after the fact, that their product really should be held only to a much more limited standard of performance.

But since the narrow claim to be a valuable "low cost, supplementary" coverage is closer to the actual intent of cancer insurance than the grand designs often suggested in its marketing, this claim certainly deserves close scrutiny in its own right.

Beginning with the assertion that cancer insurance is a low-cost coverage, it is immediately necessary to add that price is not the same as value, and low cost is not necessarily the equivalent of a bargain. Many products that can be bought for a relatively low price may be worthless or almost worthless to the buyer, and very few consumers may want to squander money on a product of dubious value, even if it is available at a relatively modest price.

With annual premiums of from $30 to $75 for an individual and from $45 to $114 for a family, cancer insurance is clearly not as expensive as conventional broad-scale health insurance.(23) But how much value does it provide?

There are various ways to measure the value of an insurance policy. One of the most important measures is the "loss ratio" or benefit-to-premium ratio. At its simplest, a loss ratio expresses the claims paid by a company -- i.e. the benefits actually paid out to consumers under a particular policy -- as a percentage of each premium dollar that the company collects. If, in a particular year, a company pays claims amounting to 80 cents for each premium dollar collected for a policy, the policy's loss ratio is 80%. In general, the higher the loss ratio, the greater the benefits received by the entire group of consumers holding the policy.(24)

The portion of each premium dollar that does not go to pay claims incurred in a particular year is instead used to cover the insurer's administrative and selling expenses, to pay taxes, and to contribute to policy "reserves" -- amounts of money set aside to earn interest and to help pay the increasing claims from policyholders that are expected in future years. Stock insurance companies, including the four cancer insurers whose policies are examined in this study, also retain a portion of each premium dollar as profit. The higher the total amounts set aside for expenses, taxes, reserves and profits, the lower will be a policy's loss ratio -- and the amounts actually paid to consumers -- in any particular year.

Among health insurance policies, incurred loss ratios can range from about 95% down to 25% or less. Group policies sold through employers or other organizations have the least administrative and selling expenses and can achieve the highest loss ratios. The expenses associated with non-group policies are larger, but loss ratios for non-group policies providing broad health insurance benefits may be 80% or above. Policies offering more restricted benefits have lower premiums than those providing broad coverage, but the amount of each premium dollar going to selling and other costs tends to be proportionately higher. Their loss ratios are lower.

If cancer claims were as large and as common as cancer insurers suggest, and if cancer policies delivered the sweeping benefits that their selling presentations imply, one would expect the loss ratios for such policies to be relatively high. Quite the contrary is true, however.

Union Fidelity's cancer policies, for example, generated a collective loss ratio of 23.4% for business written in Massachusetts between 1975 and 1978.(25) Similarly, American Income's two major cancer policies showed a loss ratio of approximately 25% during the period January 1976 through September 1978.(26) Between January 1977 and July 1978, American Family's cancer policies showed an incurred loss ratio of 42.5%. But the three most popular American Family cancer plans, which account for more than 70% of its cancer premiums in Massachusetts, showed an incurred loss ratio of 33.2% during the same period.(27)

Cancer insurers would be quick to point out that any loss ratio computed for a relatively short period -- for one year or even for several years -- might tend to understate their overall policy experience. In testimony prepared in behalf of American Family, and presented to the California Insurance Department, consulting actuary William O'Dell observed:

> . . . as a block of [cancer insurance] business stays on the books, the people get older, the loss ratio goes up. . .
>
> We have traced the loss ratios on blocks of business through the years. And, as expected, we find these loss ratios go up.(28)

It is true that the loss ratios for cancer insurance policies gradually rise over time, as policyholders age and present more claims and as the claim reserves set aside in previous years are gradually returned to claimants in increasing amounts. For the large number of cancer insurance policyholders who keep their policies only one or several years, however, the gradual increase in loss ratios is one more example of a benefit more illusory than real.

Among a national group of consumers who bought American Family policies in 1975, for example, the Division of Insurance has examined the rate of lapsation (the percentage that dropped their policies at one-year intervals) compared with the gradual increase in loss ratios over time.

In 1975, the year of issue, the loss ratio applicable to this group of policyholders was 10%. Thereafter it increased at one-year intervals to 31%, 44%, 48%, and, for the fifth year, to 52%.(29)

Only about half of the original group of policyholders kept their policies at least to the fifth year, when the policy was paying out 52 cents for each premium dollar collected. For the other half who gave up their policies after four years or less, the American Family policy achieved loss ratios ranging from 10% to 48%. Half this group, or 25% of the original group of policyholders, gave up their coverage after only one year -- when the policy was paying 10 cents in benefits for each premium dollar collected.(30)

For consumers who do not give up their cancer coverage after a few years but keep it for the long term, gradually rising loss ratios do signify improved policy performance in the later years. To judge long-term policy performance, however, it is necessary to compare all the benefits paid over time with all the premiums collected over time. The improved loss ratios of later years must be offset against the meager loss ratios of the early years.

One way to do this is to calculate the anticipated loss ratio, which relates the present value of all benefits expected in the future to the present value of all premiums expected in the future. This ratio, an estimate, is calculated for a lengthy period -- usually 25 or 30 years -- which the insurer views as the lifetime of a policy. It is, in essence, an average of the loss ratios that the insurer expects for a particular group of policyholders (e.g., those who purchase a policy in 1979) over each year of the policy's lifetime. (31)

Among the four cancer insurers examined by the Division of Insurance, American Family is the only company that has calculated an anticipated loss ratio for its cancer policies and presented it for public discussion. Consulting actuary E. Paul Barnhart, using American Family's data regarding past performance of policies and acting in the company's behalf, has calculated an anticipated loss ratio of 56.09% for the company's cancer policies. Over a 30-year period, according to his estimate, American Family's cancer plans will pay benefits of 56 cents for each dollar of premiums that the company collects. (32)

American Family's data also show that the outlook for long-term performance of the company's cancer policies is unlikely to improve. The loss ratio or benefit portion of the premium dollar can rise no higher than permitted by the company's habitual performance in regard to expenses and profit. As reported in the last chapter, American Family has consistently fueled sales growth through lavish compensation packages for its sales force (including agent commissions of from 20% to 50% of first year premiums and 10% per year thereafter) and has shown a comparable zeal for growth in profits. According to the company's own figures for 1977, 27.3%

of premiums went for sales commissions and operating expenses-while another 16% was allocated to profits and income taxes. The "company" share of the premium dollar thus totaled almost 45¢.(34)

So long as American Family maintains its present priorities for distributing the premium dollar, and particularly its present level of concern for the remuneration of sales personnel and stockholders, it is unlikely that the anticipated loss ratio will ever exceed 56%. And, if actual loss ratios are higher than those expected due to an increase in cancer incidence and claims, the apparent gain for consumers would probably be shortlived. Although the policyholder has the right to renew his American Family policy from year to year, the company reserves the right to seek increased premiums when claims exceed their present expected rate of growth.(35)

Although comparably detailed long-term loss ratio data are not available for the other three cancer insurers examined by the Division of Insurance, there is no reason to believe the overall performance of their cancer policies is better than that of American Family and some reason to doubt that it is as good. As has been seen, the available incurred loss ratios for periods of one or several years are lower for Union Fidelity and American Income than for American Family. American Income has a commission structure even more spendthrift than American Family's: the company pays agents and sales managers amounts that can reach 70% of the first year premiums, and 20% per year thereafter. On a continuing basis, sales commissions alone consume about 30% of every American Income premium dollar.(36)

The dearth of company information and analysis on claims payouts as a share of the premium dollar over the short or the long term constitutes one further obstacle to rational purchase decisions about cancer insurance. The most charitable interpretation of this information gap is that most cancer insurers are not interested in encouraging a rational analysis of their policies; a less charitable explanation is that they actively seek to suppress facts whose negative impact would be immediately and palpably clear.

American Family deserves commendation for its relatively greater attention to the need for a careful assessment of the long-term performance of its policies. Because it sells more than half of all cancer insurance, American Family's data may for now be regarded as the most definitive and relevant information available. What these data show, however, is hardly consoling to the consumer who is interested in the best possible return on limited health insurance dollars.

Returning anticipated benefits of no more than 56 cents per premium dollar to all consumers over the 30 years of a policy's lifetime, and returning only 10 to 48 cents on the dollar to the 50% of purchasers who keep their policies four years or less, cancer insurance clearly is no bargain.

Benefits and Supplemental Needs

With only about half of every cancer insurance premium dollar available now or in the foreseeable future as benefits for cancer victims, it would seemingly require a very special and compelling need to justify a rational purchase of a cancer policy. Cancer insurers assert (1) that there is a compelling, practically universal need; and, at least implicitly, (2) that their policy meets the need effectively. Both assertions are untrue.

The need for cancer coverage. The case that cancer insurers attempt to make regarding the universal need for cancer insurance rests mainly on two premises. The first is that cancer is a very expensive disease. The costs run to billions of dollars annually and perhaps $20,000 to $40,000 per cancer victim, the insurers claim in their sales presentations and public statements; without cancer insurance, they warn, many consumers may face financial ruin.

As pointed out in the first chapter of this study, however, the aggregate cancer cost estimates frequently cited by cancer insurers are irrelevant for reaching any reasonable individual determination about the need for cancer insurance. And the individual cost estimates are too high.

A Division of Insurance analysis of the principal existing studies of individual costs suggests that a more accurate estimate of the average health care costs per cancer victim is $10,000. (37)

This is hardly an insignificant amount, particularly since the range of costs includes considerably higher costs for some victims. It does provide a more useful point of reference for evaluating the need for cancer coverage than the much higher average estimates presented by some insurers. Although the costliness of cancer is a valid premise, the cost is not as high as cancer insurers suggest.

The second premise advanced by cancer insurers to demonstrate a universal need for their product is that conventional health insurance is a universally inadequate resource for meeting the high costs of cancer care. As shown in the first chapter, some cancer insurers make no mention at all of underlying health insurance in their sales presentations, thereby suggesting that cancer insurance is the sole available resource to meet the need. Others mention conventional health insurance only to emphasize its presumed inadequacies.

In their statements to insurance regulators, of course, cancer insurers acknowledge that conventional health insurance is the consumer's primary resource for meeting cancer costs. Cancer insurance, they then argue, at least fulfills a nearly universal need for supplemental cancer coverage.

Whether cancer insurance is portrayed as a major or a limited source of coverage, there is no merit in the argument that it fills a universal need caused by the general failure of conventional health insurance to pay for cancer care.

That idea, whether stated or implied, deceptively focuses the principal attention of consumers on the really secondary question of total cancer costs, and away from the central issue of their own existing health policy's capacity to meet those costs. It obscures the fact that many conventional health insurance policies will indeed pay most or all of the costs of medical care for cancer.

In Massachusetts specifically, at least 50% of consumers (and probably a much higher percentage) already have group or non-group insurance policies that cover most or all of cancer costs. One policy alone -- Blue Cross and Blue Shield's group Master Medical policy -- provides very comprehensive protection for about 40% of the state's under-65 population.(38)

The Master Medical policy covers 100% of hospital costs for room and board and other inpatient services (including radiation therapy and chemotherapy) as well as 95% of costs for a surgeon, assistant surgeon and anesthesiologist. Besides paying 100% of costs for a nearly comprehensive array of hospital-based outpatient services (also including radiation therapy and chemotherapy), the policy covers 95-100% of costs for many non-hospital outpatient services including physicians' home and office visits, prescription drugs, laboratory and pathological services, home health care, physical therapy and prostheses. Skilled nursing facilities are also fully covered, for an unlimited number of days.

Similarly, about 50% of consumers aged 65 or above have very comprehensive protection against cancer costs through a combination of Medicare and the supplementary Medex policies (particularly Medex 3) issued by Blue Cross and Blue Shield.(39)

When average individual costs are put in perspective and when the scope of commonly held conventional health insurance policies is carefully considered, it is apparent that there is no universal, or nearly universal, need for additional cancer coverage. For the significantly less than half of Massachusetts residents whose conventional health insurance provides less than comprehensive medical benefits, there may be some degree of need for *supplemental* coverage. Cancer insurance is one available type of supplement.

The supplemental performance of cancer coverage. Most cancer insurers seem to assume that if they offer any pattern of benefits providing extra cash for cancer expenses, they *ipso facto* provide a useful and valuable supplemental coverage. American Family has, however, advanced at least one rough standard for judging the performance of its policies as cancer supplements. Its goal, the company says, it to provide "50 percent of the cost of care and treatment" for cancer.(40)

Contrary to the expectation created by this statement, however, a Price-Waterhouse audit for the Division of Insurance has determined that for a representative sample of Massachusetts insureds, American Family actually paid only 23.4% of submitted cancer costs. Although American Family itself had calculated a

37% rate of compensation for all submitted charges, Price-Waterhouse concluded the company's figures were "unreliable" because "charges recorded were generally unsubstantiated." The audit findings are summarized in Table 3.(40a)

The Division of Insurance has also undertaken its own more general study of how well cancer insurance policies are able to supplement underlying coverage for cancer care. For purposes of this analysis, average costs incurred by cancer patients were examined in three broad categories corresponding to inpatient hospital, surgical, and outpatient care. Average costs were then compared with the benefits available under the typical cancer policy.

Table 4 presents estimates of average inpatient hospital costs for cancer-related stays, compared with the benefits that could be expected from the typical cancer policy. Derived from the Third National Cancer Survey, the average cost estimates range from $2,800 for the first admission to $2,100 for the third and subsequent admissions.(41)

The typical cancer insurance policy -- paying $60 per day for the first seven days of hospitalization and $30 per day thereafter, and 10% additional for drugs -- would cover about 29% of the average cost for a first admission if all services were related to definitive cancer treatment and not merely to diagnostic procedures, which are excluded.(42)

Table 3

Cancer Costs Compared to Payments Made by American Famil

(Price-Waterhouse Audit for the Division of Insurance)

	Benefits paid	Charges	Benefits paid as a percentage of charges
Hospital room fees	$16,230	$ 53,869	30.1%
Surgeon's fees	6,725	16,923	39.7
Drug charges, in hospital	1,483	7,837	18.9
Anesthesia fees	2,000	5,528	36.2
Radiation therapy and chemotherapy	7,582	11,152	68.0
Physician visits, in hospital	1,020	3,808	26.8
Miscellaneous (e.g., ambulance, blood)	782	1,371	57.0
Noncovered charges included in claims filed (e.g., operating room)	0	52,502	0.0
Total	$35,822	$152,990	23.4%

Table 4

Cancer Hospital Costs Compared to Payments Expected from Typical Cancer Policy

Type of Hospital Admission	Average Length of Stay	1970 Cost of Stay	1978 Cost of Stay	Payment Expected From Typical Policy	Payment as % of Cost
First Admission	17.4 days	$1551	$2792	$805*	29%*
Second Admission	13.9	1243	2237	690	31
Third and Subsequent Admissions	12.8	1174	2113	653	31
All Admissions	15.6	1399	2518	746*	29 *

*This figure assumes all the days of the admission involve treatment. The figure thus represents the maximum that would be paid.

Since one out of ten cancer patients receive no treatment during their first admission, the average compensation paid by the typical policy for first admissions is probably about 26%.(43) Subsequent admissions would be compensated at a rate of about 31%. Cancer patients are more likely to be hospitalized longer and to incur greater costs during first admissions, and first admissions are more likely to occur than any subsequent admissions.(44) Accordingly, the lower rate of compensation paid by the typical policy for first admissions is entitled to more weight in determining the policy's overall rate of compensation for inpatient hospital costs, which may be estimated at under 30%.

The Price-Waterhouse audit of paid American Family claims confirms this conclusion. The audit found that American Family paid Massachusetts claimants 29% of submitted charges for hospital room and drugs. Since actual hospital charges include additional amounts for miscellaneous services (such as operating room charges) that are not compensated at all by American Family, paid claims as a percentage of total hospital charges would be somewhat less than 29%.(45)

According to the Third National Cancer Survey, three out of four cancer patients undergo surgery in the course of their illness.(46) Since data is lacking on overall surgical costs, the Division of Insurance reviewed Massachusetts Blue Shield cost data for five diverse types of cancer -- breast, colon, lung, prostate and ovary -- that account for about one-half of all new cancer cases.(47)

Table 5 presents average costs for the primary surgeon for each type of surgery, and compares these costs with the maximum amount payable under each of the five cancer policies examined by the Division that provides a fee schedule for surgical benefits.(48)

Depending on the type of cancer, these policies pay from 33% to 55% of the 1977 cost for the primary surgeon. Since surgical costs continue to rise while the policy fee schedules remain fixed, the applicable percentages today would be lower.

Moreover, actual costs would include additional charges for an assistant surgeon and for follow-up surgical visits in many cases. The limited Blue Shield data that is available for frequently performed surgical procedures, for cancer and other health problems, shows that 15% of all operations require an assistant surgeon and follow-up visits occur after 40% of all operations. For those requiring these services, up to 30% in additional costs must be incurred. Spread among all surgical patients, these services add about 5% to surgical costs on average. These additional costs are not shown in Table 5.(49)

Overall, the typical cancer policy probably pays about 40% of surgical costs. The Price-Waterhouse audit of American Family claims confirms this estimate.(50)

Besides inpatient hospital and surgical costs, the average cancer patient also incurs substantial costs for outpatient care at hospital outpatient departments, other clinics, doctors' offices,

Table 5

1977 Estimated Costs of Primary Surgeon Compared to Payments Expected from Typical Cancer Policy

Bodily Part Surgically Removed	Estimated Cost of Surgeon	Payment Expected from Typical Cancer Policy	Payment as % of Cost
Breast	$ 577	$250 (estimate based on $200 fee for removal of one breast and $300 for both)	43%
Colon	770	$300 (resection of the ascending or transverse colon)	39
Lung	1200	$400 (complete lobectomy)	33
Prostate	726	$400	55
Ovary	450	$200 (estimate based on $400 fee for removal of uterus, tubes and ovaries)	44

and at home. Outpatient costs include those for chemotherapy and radiation therapy, home nursing, drugs, prosthetics and physical therapy. As Table 6 shows, outpatient services are frequently needed and may cost cancer patients hundreds or thousands of dollars. (51)

Based on data from the Third National Cancer Survey and updated to 1978 dollars, the table shows that estimated outpatient costs -- and inpatient and outpatient surgery -- average about $2,800 per cancer patient. Adjusted to eliminate the surgical costs, the survey data indicate average outpatient costs of about $2,000. (52) Since many of the patients whose expenses were reviewed had received a diagnosis of cancer as recently as six to twelve months before the study, the $2,000 estimate may significantly understate total lifetime costs for outpatient care. (53)

The typical cancer policy covers very few of the outpatient costs of cancer patients, even though for some patients these costs may be greater than the cost of inpatient care -- and even though these costs are the least well covered by some conventional health insurance policies. None of the six cancer policies examined by the Division covers drugs outside the hospital, home nursing, physical therapy, special equipment, prosthetics, or nursing home care. According to Table 6, these expenses account for over 40% of total outpatient costs.

Table 6

1970, 1978 Estimated Costs of Outpatient Services

Service	% of Patients Who Used Service	Mean Costs for Patients Who Used Service - 1970	Mean Costs for Patients Who Used Service - Adjusted to 1978	Mean Cost for All Cancer Patients - 1970	Mean Cost for All Cancer Patients - Adjusted to 1978
Hospital Outpatient Clinics, Inpatient and Outpatient Surgery, Doctor Office Visits	100%	$1086	$1955	$1086	$1955
Nursing Home	11	2107	3793	225	405
In-home Nurse	10	1036	1865	101	182
Drugs	69	121	218	84	151
Physical Therapy	5	152	274	8	14
Special Equipment	16	93	167	15	27
Prosthetics	11	73	131	8	14
Other	65	68	122	44	79
Total				$1571	$2827

The remaining 60% of outpatient costs include charges for hospital-based outpatient services and physician services. None of the six cancer policies covers these costs, except for benefits applying specifically to the administration of radiation therapy and -- in the case of one policy -- chemotherapy.

After surgery, chemotherapy and radiation therapy are the most common forms of cancer treatment. For most cancers, the chances are high that one or both of these treatments will be used. For example, 51% of a large group of lung cancer patients received one or the other, and 11% received both. Among leukemia patients, 74% received chemotherapy.(54) For many patients, the outpatient costs of these therapies can be very high:

> The most expensive course of chemotherapy is Adriamycin, which is used for a number of different types of cancer. This. . . is typically administered on an outpatient basis and may be used in combination with other types of therapy, such as surgery. The cost of Adriamycin alone may cost up to $200 per injection, which could add up to well over $3000.
>
> Radiotherapy, administered on an outpatient basis, may involve from several days of consecutive treatment to a program of four to six weeks. The initial visit, including the physics, the computer analysis, body contours, and doctor's consultation average between $98 and $148. For example, each subsequent visit for a radiation treatment may cost $23 to $38. Therefore, a four-week course of treatment for 20 visits would cost between $460 and $760. These figures are for the Harrisburg (Pa.) area, which is considerably lower than treatment in Philadelphia or Pittsburgh.(55)

Five of the six policies examined by the Division cover radiation therapy to a maximum amount of $1,000 or $1,500, whether the treatment is received on an inpatient or outpatient basis. Outpatient chemotherapy charges are covered only by American Family's A-6021 policy, but they are subject to a joint maximum, along with radiation therapy, of $1,000. This also is a combined limit for inpatient and outpatient services.

The Price-Waterhouse audit found that American Family paid 68% of all charges submitted for payment under its combined chemotherapy-radiation therapy benefit provision.(56) Assuming a uniform distribution between inpatient and outpatient care, it appears that American Family's policy paid 68% of the outpatient costs for these two services.

Overall, American Family's unique inclusion of some coverage for chemotherapy probably means it compensates actual outpatient costs at a rate slightly higher than other cancer policies. However, because of the relatively low limit on this benefit and on the benefits for radiation therapy found in other policies, and because of the uniform exclusion of all other outpatient services, it is obvious that the typical cancer policy compensates only a limited percentage of total outpatient costs. For American Family, the rate of compensation may approach 40%; for other policies, the rate is considerably lower.(57)

In summary, it can be seen that the typical cancer policy compensates under 30% of average inpatient hospital costs, about 40% of surgical costs, and less than 40% of outpatient costs of cancer victims. When these figures are consolidated, taking into account the major proportion of total costs that are hospital-related, it appears that the typical cancer policy covers only about 30% of total cancer costs. This percentage further erodes over time because of the effect of inflation on fixed benefit limits. As it does, the actual performance of cancer insurance contrasts all the more dramatically with the leading cancer insurer's widely publicized intention to pay 50% of total cancer costs.

Even if the performance more closely resembled the intention, American Family's self-avowed standard of performance for supplemental cancer insurance is, on its face, simplistic and inflexible. By addressing itself only to the compensation of a specified percentage of total cancer costs, the standard ignores the widely varying coverage of underlying insurance policies.

Whatever the percentage of costs actually compensated by a cancer policy at any given time, it is inevitable that some cancer insurance policyholders will receive too little supplementation, while others will receive more than enough. If the current rate of compensation is about 30%, for example, then a consumer with a conventional policy that pays only 50% of overall costs will receive too little compensation to meet his need; a consumer with a policy paying 80% of costs will receive too much.

Addressing itself only to an overall compensation goal, moreover, the standard also ignores the varied individual costs of cancer patients. For some patients, for example, outpatient therapy may be a predominant treatment mode; despite the fact that outpatient services are the least well compensated by some conventional health policies, the typical cancer policy establishes strict limits on benefits for radiation therapy, generally does not cover chemotherapy, and uniformly excludes most other outpatient costs. By its rigid, compartmentalized allocation of fixed benefits to different types of cancer costs, the typical policy practically guarantees that many significant needs of individual cancer patients will not be met.

In the end, it is clear that the erratic supplemental performance of cancer insurance is based on its poor supplemental policy design. Just as the selling of cancer insurance trades on the myth of a universal need for cancer coverage, the design of the product indulges the further illusion that among those who do need some supplemental protection, the kind and degree of need is uniform. Just as cancer insurance sales presentations consistently neglect to acknowledge and explain the primary role of conventional health insurance in meeting cancer costs, the cancer insurance policy is designed with monumental disregard for the need to coordinate flexibly with varied underlying policies.

Aiming really to provide nothing more than miscellaneous extra cash benefits for cancer victims, the typical cancer insurance policy provides no more. Simplistic in conception, clumsy in execution, the product poorly performs even its limited supplemental task.

Alternative supplements. In addition to other flaws, cancer insurance also suffers the obvious but fundamental limitation that its name proclaims: It will not pay for any illness or injury except cancer. Despite its costliness, cancer is not the only expensive health problem for which consumers must try to obtain adequate insurance protection. Cancer in fact accounts for only 5% of total medical costs, and a cancer policy accordingly provides protection for about 30% of that amount, or 1.5% of total medical costs.(59)

As American Family has acknowledged in a statement for the U.S. Securities and Exchange Commission, its product is not an adequate substitute for "major medical" insurance -- a conventional broad-scale policy that provides extensive coverage of inpatient and outpatient costs for nearly all illnesses and injuries.(60) Cancer insurers often assert, however, that some consumers cannot afford the premiums for such comprehensive supplemental coverage and therefore would be better served by supplemental cancer coverage than by none at all.

Fortunately, the choices available to consumers are not so limited as this argument suggests. For prices not very much -

higher than the premiums typically charged for cancer insurance, consumers can purchase a non-group "catastrophic" insurance policy providing supplemental protection for cancer as well as other illnesses and injuries. Such policies can be flexibly coordinated with underlying coverage by means of large deductibles approximately equivalent to the value of potential benefits from the underlying policy.

At a price of $80 a year for an individual or $160 a year for a family, for example, one commercial insurer offers a catastrophic major medical policy with a deductible of $7,500 -- an amount whose benefit equivalent would be provided by many existing basic insurance policies. This catastrophic policy pays 90% of covered medical expenses in excess of the per illness deductible. Benefits are payable for ten years from the time when the deductible is first met; the deductible itself must be met within two years after an illness first manifests itself.(61)

The policy covers inpatient hospital charges for room and board and other services and supplies; inpatient and outpatient fees of surgeons and anesthiologists; and outpatient services including physician fees, laboratory tests and diagnostic services, radiation therapy, physical therapy, prescription drugs (including chemotherapy) and home care.

Another commercial insurer offers a similar catastrophic policy providing nearly identical benefits; the policy pays 100% of covered medical expenses on excess of the deductible to a maximum of $1,000,000. The policy has a ten-year benefit period from the time when medical expenses are first incurred, and a three-year accumulation period. As might be expected with its higher level of benefits, premiums are higher. Family coverage when the parents are both age 40 costs $210 per year with a $10,000 deductible. Premiums for younger persons are lower, while those for older persons are higher.(62)

Other companies sell policies that provide benefits similar to the policies already described.(63) Any of these policies will provide greater cancer treatment benefits than a cancer insurance policy while providing comprehensive protection for all other illnesses -- including complications of cancer and illnesses caused by cancer treatment -- and accidental injuries. An excess major medical policy clearly provides broader coverage for the dollar and is a better supplemental coverage than cancer insurance.

Conclusion

From the claim to be the indispensable panacea for "astronomical" cancer costs to the claim to be at least a valuable supplementary policy, the diverse and sometimes contradictory representations of cancer insurance must one by one retreat before the advancing frontier of knowledge about how the product actually performs its chosen tasks.

Providing very modest benefits, on average, to supplement the conventional health insurance it habitually ignores or derides, covering cancer costs haphazardly and other health costs not at all, collecting a dollar of premiums to deliver only about fifty cents in benefits, cancer insurance is not the best available health insurance supplement nor even a moderately good supplement in its own right.

III. THE REGULATION OF CANCER INSURANCE

The two preceding chapters have documented serious problems in the cancer insurance market. To the extent the four companies discussed here reflect the general market -- and there is good reason to believe the reflection is accurate -- the pattern of consumer abuse is both conspicuous and disturbing. Combining exploitative sales practices with a paucity of benefits, cancer coverage embodies the worst possible extremes of health insurance marketing and product design.

Not surprisingly, the marketing excesses of cancer insurance usually attract the most consumer and regulatory attention. The shrill hysterics of advertising about cancer incidence and costs, the stark and misleading manipulations used in cancer insurance sales presentations can scarcely be ignored. Yet these marketing practices grow from a kind of logic. The policies and premiums are nearly identical, so each company has staked a claim on a small but dependable part of the larger market. In order to wring the greatest sales potential from a finite population, each company has reduced its sales pitch to the lowest common denominator: uncertainty and fear, skillfully evoked.

Not that the performance of cancer insurance, after a consumer has purchased it, is less worthy of attention. Like any fixed-benefit supplement, cancer insurance is vulnerable to inflation and runs the risk of only haphazardly complementing the consumer's basic coverage. Add to those caveats the uncommonly harsh policy provisions regarding waiting periods, diagnosis, and treatment; one then has a fairly clear picture of a policy that is at best marginally adequate.

Cancer insurance is not a fad or aberration; it is a small, but growing, part of the country's health insurance industry. And as long as cancer instills fear in the American population, cancer insurance will flourish. In the future, as the median age of the American population rises, the collective dread of cancer -- a disease mainly of middle and old age -- will almost certainly rise to a comparable degree.

Given the present problems of policy design and marketing, it seems no exaggeration to state that insurance regulators have just begun to see the abuse cancer insurance can breed. In light of the analyses presented in this report, it must be obvious that this coverage warrants strict and vigorous regulation. Closer regulatory supervision depends, in turn, upon the insurance commissioner's powers to regulate health insurance, especially individual health insurance. Generally, the Massachusetts laws support four possible means of regulation:

- --Enforcing general standards more vigorously;
- --Constructing specific standards for cancer insurance;
- --Requiring cancer insurance to be sold only in conjunction with broad-scope coverages;
- --Banning cancer insurance.

The problems documented in this report do not dictate any one approach, and each approach might work -- or might have to suffice -- under a particular set of circumstances.

Enforcing existing standards

When confronted with problems like those posed by cancer insurance, the regulator's initial, and quite valid, response is to seek a remedy in the existing law. Most states' regulation of cancer insurance, in fact, relies upon the statutes and regulations that govern health insurance generally. In Massachusetts those standards hold, for example, that marketing materials and policy forms must be free of "the tendency to mislead," in fact or in implication.(1)

By applying these standards rigorously and consistently, there is a good chance that the Division could eliminate the worst marketing abuses and the most deceptive policy restrictions. It is reasonably clear that the way cancer insurers use incidence and cost statistics could be greatly modified by using existing authority granted by the standards, seven states (including Massachusetts) also identify and regulate dread disease policies as a distinct category of health insurance.[2] The details of regulation vary from state to state, but generally they have adopted the National Association of Insurance Commissioner's recommendations regarding specific minimum benefits for this kind of coverage. The NAIC standards affect only slightly the basic design of most cancer policies, however, and do not regulate marketing practices at all.[3]

A somewhat better approach has been adopted by West Virginia and Pennsylvania, which have prohibited the individual benefit limits common to most cancer policies.[4] This approach strives for a logical correlation between the policy benefits and the financial needs of cancer victims. If Massachusetts were to adopt equivalent standards, cancer insurance policy forms would be improved, and the Division could assure consumers of at least a simpler, more flexible coverage.

Unfortunately, adopting specific standards for cancer insurance marketing is another story. Such standards would perforce include what must, as well as what must not, be said to give the consumer reasonable expectations about cancer coverage. Existing general laws and regulations more or less adequately address what may not be said; specific standards would therefore stipulate what disclosures must be made to the prospective policyholder.

Being unable to use the current shorthand ("one in four," "two out of three families") for cancer risk, cancer insurers would have to

New York specifically allows cancer coverage to be sold as a part of or as an amendment to basic hospital, basic medical or major medical insurance, each of which is subject to strict regulatory standards. This kind of regulation effectively creates an additional, although narrow, layer of cancer coverage atop the broad-scope policy.

One might ask whether it is good public policy to encourage (at least implicitly) the purchase of cancer insurance with basic coverage, when supplemental major medical insurance is most surely a more important priority. New York's regulation also leaves the cancer policy's internal design unchanged, despite its numerous shortcomings.

Nevertheless, by assuring that the coverage can be purchased only in conjunction with a more comprehensive policy, New York's approach alleviates some of the concerns about the defects of the cancer insurance product. If this approach were enhanced by standards applying directly to the cancer component of coverage, it could provide a generally effective solution for a troublesome regulatory problem.

There is a similar solution for concerns about cancer insurance marketing. Once cancer insurance is made an adjunct coverage, instead of erecting complex standards for the advertising and sale of cancer insurance, the regulator can promulgate regulations prohibiting insurers from giving undue prominence to the cancer portion of the coverage. When these two changes are made, the public benefits in two ways. First, the worst marketing abuses are eliminated; a reduced emphasis on cancer coverage advertising will predictably lessen the opportunities to excite consumers' fear about the disease or its costs. Second, the undue prominence standard has far more intuitive meaning than a more general standard involving "the tendency to mislead." The insurers offering cancer coverage could thus assume a greater responsibility for the compliance of marketing materials and sales presentations.

Banning cancer insurance

Considering the many problems of cancer insurance, a ban on the product as it is now constituted seems reasonable, and several states have resorted to this ultimate regulatory approach. Using broad existing statutory authority to prevent deceptive practices and to eliminate coverages of little economic worth, the Massachusetts commissioner of insurance could implement such a ban administratively; or a prohibition could be enacted by the state legislature.

In 1975, Connecticut's legislature passed a law ending the sale of cancer insurance policies.(6) According to one published report, there were three reasons behind the ban: poor value; exclusions for complications caused by cancer; and, predatory sales practices.(7) Another source, a Connecticut legislative researcher, indicates that cancer insurance was rendered obsolete by that state's Comprehensive Health Care Act, which mandated universal availability of catastrophic illness coverage.(8)

The New Jersey Insurance Department implemented an administrative ban on the sale of cancer insurance in 1976, following a prolonged history of unsuccessful attempts to regulate the product by more moderate means.(9) For several years prior to 1967, the Department had routinely disapproved dread disease policies, mainly because it was believed that the promotion of such coverage was "inherently misleading." (10)

When the Department decided in 1967 to allow the sale of cancer coverage as an amendment to basic and major medical policies, cancer insurers responded by selling combined coverage but stressing the cancer component in their promotional materials.(11) This aggressive quest for sales was facilitated by the lack of an "undue prominence" standard in the New Jersey rule, and heightened by government reports that New Jersey's cancer morbidity rate was among the highest in the nation.(12) Concerned about this renewed appeal to consumer fears, and again citing the inherently misleading nature of sales promotions, New Jersey banned the product entirely in 1976.

In view of the serious problems with the marketing and design of cancer insurance documented in this report, the sales prohibitions earlier enacted by Connecticut and New Jersey seem one quite plausible regulatory response. Like the other regulatory options that have been discussed, a ban on cancer insurance sales would be aimed at the termination of the pervasive abuse that this product currently engenders; but it would achieve this result more simply, swiftly and effectively than any of the alternatives.

Conclusion

This study presents the first extensive examination of cancer insurance marketing and cancer insurance policies. Although members of the research and education staff had varied impressions of cancer insurance when the study began, the accumulating facts gathered from many sources soon produced agreement that the product was generally and badly flawed.

Working with an unprecedented volume of objective data, the staff also developed a keen sense of the numerous specific problems that would have to be addressed if cancer insurance ever were to be regulated satisfactorily. When we subsequently reviewed the principal options for cancer insurance regulation, we held no brief for any one approach and indulged no illusion that any perfect, indispensable regulatory formula might be found.

Nevertheless, the available regulatory options are not interchangeable and the choice among them is not unimportant. More than anything else, aside from existing statutory authority, the choice probably depends on whether a regulator perceives the manifold problems of cancer insurance as integral or discrete.

If the problems are seen as so many items on a miscellaneous checklist, then the use of miscellaneous general and specific regulatory standards might seem an appropriate choice. Such remedies would require of the regulator an extensive knowledge, an unflagging attention to detail, and a willingness and ability to make a continuing commitment of staff and financial resources; but under such conditions, they could be generally effective in removing some of the worst abuses of cancer insurance.

On the other hand, if the problems of cancer insurance are perceived to be interrelated parts of an entire pattern of selling and product design that makes little common or economic sense and thrives fundamentally on the exploitation of consumer ignorance, uncertainty and fear about one disease, then a piecemeal regulatory approach might seem little more than a valiant but futile attempt to apply Band-Aids to an open wound. If a regulator believed a single-disease policy had any conceptual validity at all, he might desire to regulate the basic design of the coverage directly and systematically, rather than indirectly and incrementally. He might also wish to assure that the coverage could only be used for its intended supplemental purpose by requiring that it be sold only in conjunction with a broader policy. If he judged that a single-disease policy makes no logical and economic sense at all, he might prefer an outright ban on the sale of the product.

The members of the research and education staff have observed cancer insurance too closely to believe that its varied excesses and shortcomings are discrete, coincidental, entirely inadvertent. Our perception of the interrelated nature of the problems we have documented leads us to recommend either the third or the fourth regulatory options discussed in this chapter -- either directly requiring cancer insurance to meet realistic tests for product design and value, and to be sold only as an adjunct to a broader policy; or prohibiting its sale.

NOTES

INTRODUCTION

1. Gallup poll results, reported by John B. Amos, "Twenty Years of Stewardship: Cancer Insurance Comes of Age," advertisement appearing in Time and reprinted by American Family.

2. Jim Montgomery, "Chief of American Family Beats Back Challenge to Power," Wall Street Journal, April 24, 1979, p. 20.

3. R-L Associates, an independent survey research firm, sampled the Massachusetts policyholders of Union Fidelity Life Insurance Company for the Division of Insurance. The figures in the text are reported in R-L's computer print-out at p. 17.

4. "Cashing in on Fear: The Selling of Cancer Insurance," Consumer Reports, June, 1978, p. 338.

I. THE SELLING OF CANCER INSURANCE

1. Breeze McMennamin, "A Heck of a Sales Force," Forbes, March 1, 1977, p. 53.

2. Ibid.

3. Ibid.

4. Ibid.

5. Ibid., p. 54.

6. Ibid., pp. 53-54.

7. Commonwealth of Massachusetts, Division of Insurance, Market Conduct Examination Report of American Family Life Assurance Company of Columbus, Georgia (Boston: By the Author, 1979), p. 20.

8. Equity Research Associates, American Family Corporation (AFL-16 NYSE), Institutional Report (New York: Anametrics, Inc., June 30, 1978), p. 1.

9. "Hour Power" marketing presentation for CAN (873) policy, p. 1.

10. McMennamin, "A Heck of a Sales Force," p. 55.

11. Ibid., p. 53.

12. Marjorie D. Harvey, "Cancer: The fear, the hope," Boston Globe, September 26, 1978, p. 25.

13. Equity Research Associates, American Family, pp. 2, 7.

14. "Cashing in on Fear: The Selling of Cancer Insurance," Consumer Reports, June, 1978, pp. 336-338.

15. "American Family: Big Profits from Cancer Insurance," Dun's Review, March, 1978, p. 33.

16. John B. Amos, "Twenty Years of Stewardship: Cancer Insurance Comes of Age," advertisement appearing in Time and reprinted by American Family; John Beverly Amos, "Twenty Years of Stewardship: The Truth About Cancer Insurance," advertisement appearing in Reader's Digest and reprinted by American Family.

17. E.g., form numbers B75-B, B91-BR, 124942-6.

18. Form number LBA 137-B.

19. Form number 124941-8.

19a. E.g., form numbers B 43-B, B 47-B1, B91 B.

20. Training Handbook, p. 2.

21. Form numbers A-7302, A-7303, A-7304.

22. "Hour Power" marketing presentation for CAN (873) policy, p. 3; said in conjunction with notebook pp. 20-21.

23. Ibid., notebook p. 22.

24. Form number N25221.

25. John B. Amos, "Twenty Years of Stewardship."

26. In 1977, there were an estimated 5.6 million injuries due to motor vehicle accidents. U.S. Bureau of the Census, Statistical Abstract of the United States: 1978 (99th ed.; Washington, D.C.: Government Printing Office, 1978), p. 647. In 1979, there will be an estimated 765,000 new cases of cancer. American Cancer Society, Cancer Facts & Figures (1979), (New York: By the Author, 1978), p. 3.

27. An estimated 724,000 people died from diseases of the heart in 1976 while 337,000 died from malignancies. U.S. Bureau of the Census, Statistical Abstract, p. 75. The medical treatment of heart and blood vessel diseases will cost an estimated $24.6 billion in 1979. American Heart Association, Heart Facts 1979, (Dallas: By the Author, 1978), p. 11. Cancer, on the other hand, involved direct medical costs on the order of $6 billion in 1976. Joseph Scotto and Leonard Chiazze, Jr., "Cancer Prevalence and Hospital Payments," Journal of the National Cancer Institute, LIX, No. 2 (August, 1977), p. 348.

28. Clair A. Snyder, Chairman of the Board of the Pennsylvania Division, American Cancer Society, "Testimony on Cancer Insurance," presented at the Pennsylvania Insurance Department's hearing on proposed regulations for individual accident and sickness insurance minimum standards, September 30, 1977, p. 1.

29. Ibid., p. 3.

30. American Cancer Society, Cancer Facts & Figures, p. 10.

31. Training Handbook, p. 2.

32. Washington National Life Insurance Co., form number N25221.

33. American Cancer Society, Cancer Facts & Figures, p. 6.

34. Washington National Life Insurance Co., form number N2522.

35. The ACS estimates that there will be 765,000 new cases of cancer. American Cancer Society, Cancer Facts & Figures, p. 3. The figure in the text is the result of dividing 217.6 million (the U.S. Bureau of the Census' 1978 estimate of the U.S. population) by 765,000.

36. Ibid., p. 18. The 10% figure in the text is the result of dividing 80% of 112,000 (the number of new cases of lung cancer) by 765,000 (the total number of new cases of cancer).

37. Ibid., p. 17. The 15% figure in the text is the result of dividing 112,000 (the number of new cases of colon-rectum cancer) by 765,000 (the total number of new cases of cancer).

38. "Mandatory Read-Off Letter to All Union Members."

39. "Hour Power" marketing presentation for CAN (873) policy, p. 3.

40. Training Handbook, p. 2.

41. Form number A-6437.

42. John B. Amos, "Another Perspective: Cancer Coverage Called Vital Supplement," National Underwriter, December 16, 1978, p. 13.

43. Form numbers B75-B, B91-BR.

44. Form number S-75.

45. Form number 124941-8.

46. Form number LA229R-B.

47. Form number N25221.

48. For more detailed discussion of the cost studies, see infra, Chapter II, n. 37.

49. American Cancer Society, Cancer Facts & Figures, p. 28; "Cashing in on Fear: The Selling of Cancer Insurance," Consumer Reports, p. 338.

50. Cancer Care, Inc. and The National Cancer Foundation, Inc., The Impact, Costs and Consequences of Catastrophic Illness on Patients and Families: A Report of a Social Research Study of Selected Families Stricken by Advanced Cancer (New York: By the Author, 1973).

64. Commonwealth of Massachusetts, Division of Insurance, *Market Conduct Examination Report of Union Fidelity Life Insurance Company* (Boston: By the Author, 1979), p. __. The figure was computed as follows:

Maximum benefit		$200,000
Physician	$1,200	
Nursing	1,200	
Drugs/medicine	500	
Surgery	1,000	
Anesthesia	140	
Blood and plasma	600	
X-Ray therapy	2,000	
Ambulance	1,000	
Medical Benefits	$7,640	(7,640)
/Room and Board Benefits/ Available		192,360
The policy pays room and board benefits, as follows:		
Day 1 through day 7 at $120 per day		(840)
Day 8 through day 90 at $80		(6,640)
Available after 90 days		184,880

65. According to the previous note, $184,880 is available after 90 days of hospitalization. For hospital stays greater than 90 days, the policy pays $10,000 per month. Thus, in order to collect the $184,880, one would have to be hospitalized for an additional eighteen and a half months, or 562 days. To collect the total $200,000, one would have to be hospitalized for 652 days (90 plus 562).

66. Joseph Scotto and Leonard Chiazze, Jr., *Third National Cancer Survey: Hospitalization and Payments to Hospitals*, Part A: Summary (n.p.: U.S. Department of Health, Education and Welfare, 1976), p. 8.

67. Commission on Professional and Hospital Activities, *Length of Stay in PAS Hospitals, by Diagnosis, United States, 1975* (Ann Arbor: By Author, 1976). This book presents percentiles of lengths of hospital stays by diagnosis. For example, for breast cancer, the book indicates that 99% of the patients have stays of 46 days or less. The following table presents complete percentile information for the six cancer types which are discussed in Chapter Two of this paper:

	Percentiles of Patients						
	5%	10%	50%	75%	90%	95%	99%
	Number of Hospital Days						
Cancer Site							
Breast	2	4	9	13	20	26	46
Colon	3	5	16	23	33	42	62
Lung	2	3	12	19	29	37	56
Prostate	2	3	10	15	23	30	47
Leukemia	1	1	7	14	23	30	51
Ovary	2	3	11	18	28	36	58

The 99th percentiles for the other types of cancer presented in the Commission's book are, for the most part, similar to those presented in this table.

68. Anthony J. Houghton and Ronald M. Wolf, "Development of the 1974 Medical Expense Tables," Society of Actuaries: Transactions, XXX, No. __ ( ), pp. __, __. (Reporting on the large claim volume of one insurer.)

69. Calculated from Union Fidelity computer print-out containing all Massachusetts cancer insurance claims reported during the period 1/1/77 - 8/31/78.

70. Commonwealth of Massachusetts, Division of Insurance, Market Conduct Examination Report of American Family, pp. 35, 42. The $1,278 figure in the text is the result of dividing $214,633.84 (total claims paid) by 168 (number of policyholders receiving claim payments).

71. R-L Associates asked its samples of policyholders from three companies how much of a $20,000 bill for (cancer-related) medical services their cancer policy would pay.

About two-thirds of each company's insureds responded that they simply did not know. But of those who claimed to know, the vast majority incorrectly thought their cancer policy would cover the entire bill; only about one in eight knew that their policy would pay less than $10,000, the correct response.

72. American Family, for example, considers persons with a prior history of cancer only as follows. If an applicant has a history of skin cancer, he will be accepted for internal malignancies but excluded completely for skin cancer by means of a policy rider. However, if the applicant has had melanoma, a type of skin cancer, he will not be accepted under any circumstances. Finally, if an

applicant has a history of internal malignancy, he may be accepted after underwriting review if his physician attests that there has been no recurrence of, or treatment for, cancer within the past 10 years.

73. State and Regional Training Manual, Section V, p. 5.

74. Form number N 25221.

75. "Hour Power" marketing presentation for CAN (873) policy, p. 3.

76. Union Fidelity's waiting period may not be as restrictive as the others. The company's marketing materials provide that cancer first diagnosed during the waiting period "is not covered for two years" (i.e., will be covered after two years), but this is not at all clear from the policy:

> No claim for loss incurred or disability (as defined in this Policy) commencing after two (2) years from the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of coverage of this Policy, subject to the provisions as stated in the Benefit Provisions of this Policy.

77. Administrative Procedures Manual, p. 4.

78. Diagnostic costs may indirectly be covered under some circumstances. Consider one operation in which a biopsy is performed, cancer is pathologically diagnosed immediately, and then the cancerous tissue is removed. This entire operation could be viewed as treatment related even though its initial purpose was diagnostic in nature.

79. See supra, p. 26.

80. Form A-6437.

81. The actual figure is 41%, which is the result of dividing 2.35 million (Massachusetts Blue Cross-Blue Shield's estimate of the number of its non-Medex insureds) by 5.7 million (the U.S. Bureau of the Census' estimate of the 1970 Massachusetts population). Blue Cross-Blue Shield's non-Medex policies coordinate benefits with group as well as individual policies.

82. R-L Associates' studies show an almost universal ignorance about coordination of benefits and its effects on payments made under supplemental policies. For each of the three sampled companies, more than half of the policyholders who also have Blue Cross-Blue Shield coverage (with its coordination of benefits provision) wrongly believed they could collect more than once (i.e., from more than one policy) for the same medical bills. Less than 5% of the policyholders knew double recovery is prohibited, while about one-third simply did not know.

83. According to the findings of R-L Associates, thirty-four percent of Union Fidelity's policyholders incorrectly thought their policies covered cancer diagnosed within the first 120 days of the policy. Less than 25% of those interviewed knew that there is a time limit for receiving benefits under their Union Fidelity policies.

In the American Income sample, a substantial number of policyholders incorrectly thought that their policy would pay for: nursing home care (29%); treatment incurred because of cancer therapy (30%); chemotherapy (45%).

Similar results obtained in the American Family sample. Forty-four percent of the American Family sample erroneously thought their policy would pay for diagnostic x-rays; 37% believed nursing home care was covered; 43% thought their policy paid for illnesses caused by cancer treatment.

A large number of respondents at each company, about 50%, reported they did not know whether a particular cost was or was not covered by the policy.

84. Commonwealth of Massachusetts, Division of Insurance, Market Conduct Examination Report of the American Income Life Insurance Company (Boston: By the Author, 1979), p. 7.

85. "Hour Power" marketing presentation for CAN (873) policy, p. 1.

86. "Hour Power" marketing presentation for CAN (873) policy, p. 5. American Income's "GREATEST CLOSE" is presented in conjunction with the page reproduced opposite:

> Let's assume, Brother Smith, for the moment that you are going to work for a new company tomorrow and they say to you, "You may have your choice of one of two jobs that I will suggest. Under PLAN I, your salary is $256.70 per week. Under PLAN II, your salary is $250 per week.

Similar page for Massachusetts will be substituted.

Look at it this way:

	PLAN 1	PLAN 2
Salary	$256	$250.00
Father	-0-	$6,665.00
Mother	-0-	$4,331.00
Child	-0-	$1,000-$1,000
Each Child at 21	-0-	$10,000.00
Retirement-Him-Age 65	-0-	$3,482.00 or Income
Retirement-Her-Age 65	-0-	$2,238.00 or Income
Cancer—Each Adult	-0-	$50,100.00 Each
Cancer—-Each Child	-0-	$50,100.00 Each
Total Cancer Benefit*	-0-	$200,400.00 Total

EXAMPLE IS FOR LIFE INSURANCE AGE 35

Example is for TEN UNIT policy for family of four, named insured issue age through 59. If named insured is e 60 or older at issue, premium rates are for one-half of all benefits shown.

"Under PLAN I (and God forbid), if you should be taken out of the picture, you would receive ZERO. Under PLAN II, your family would receive $6,665. Under PLAN I, if the wife should be taken out of the picture, you would receive ZERO. Under PLAN II, you would receive $4,331.

"Under PLAN I, there will be no insurance on the children. Under PLAN II, $2,000 on each child -- in your case, this means a total of $4,000 of insurance. Under PLAN I, when the children become 21, they will have no insurance. Under PLAN II, each child has an option for $10,000 of insurance regardless of his state of health.

"Under PLAN I, your retirement benefit would be ZERO. Under PLAN II, you could receive $3,482, in cash OR a paid-up life insurance policy of $5,052. For the Mrs., when she is age 65, her retirement benefit would be ZERO. Under PLAN II, it would be $2,263, in cash OR paid-up life insurance of $3,283. Her choice.

"Under PLAN I (and God forbid), if any of your family got cancer, we would pay you ZERO. Under PLAN II, there would be $35,640 of allocated benefits for each of the four of you OR $142,560 of potential allocated benefits."

Which job would you take? You have Job I. I'm offering you Job II.

87. Union Fidelity, form number 124941-8.

88. State and Regional Training Manual, Section V, p. 17.

89. Ibid., p. 19.

90. Ibid., p. 20.

II. THE PERFORMANCE OF CANCER INSURANCE

1. "Profit Clause Keeps Insurance Executive From $1 Million Pay," Wall Street Journal, April 16, 1979, p. __; Jim Montgomery, "Chief of American Family Beats Back Challenge to Power," Wall Street Journal, April 24, 1979, p. 20.

2. E. Paul Barnhart, "American Family Life Assurance Company: Cancer Expense Business," pp. 5, 6. (Photocopied.)

3. As mentioned in the previous chapter, The American Cancer Society estimates that one in four persons will develop cancer within his lifetime. Since less than half of cancer insureds remain covered for any appreciable length of time (see infra, p. 81), the one in four reference was adjusted to one in eight.

4. John B. Amos, quoted in "Cashing in On Fear: The Selling of Cancer Insurance," Consumer Reports, June, 1978, p. 338.

5. "According to a recent study conducted by the Health Insurance Association of America, group health insurance reimbursed 84.9% of all covered expenses incurred by claimants in 1977. . . Group plans reimbursed. . . 91.1% of the charges for /hospital/ room and board and 89.5% of hospital ancillary charges." Other health care expenses were reimbursed at the following rates: surgery, 83.8%; private duty nursing, 82.7%; anesthetist, 82.6%; diagnostic x-ray and lab, 81.5%; doctor visits, in hospital, 74.1%; prescribed drugs, 63.6%; and doctor visits, office and home, 59.4%. Health Insurance Institute, Source Book of Health Insurance Data 1977-1978, (Washington, D.C.: By the Author, 1978), p. 36.

6. Form CAN (873) MASS., p. 1.

7. Massachusetts General Laws, chapter 175, section 2B.

8. In response to the market conduct examination report issued by the Division of Insurance, American Income withdrew policy form CDK from use in Massachusetts as of March, 1979.

9. Anthony J. Houghton and Ronald M. Wolf, "Development of the 1974 Medical Expense Tables," Society of Actuaries: Transactions, XXX, No. __ ( ), p. __.
The standard cancer plan is identical in all respects to Form A-6021 except it has a $50,000 overall policy limit.

10. The policies presented in Table 1 are quite similar to the policies of nine other companies that were compared in Jerry S. Rosenbloom, "Cancer Insurance Study," (1977), pp. 20-23. (Mimeographed.)

11. National Cancer Institute, Cancer Patient Survival, Report Number 5 (Washington, D.C.: Government Printing Office, 1976), p. 162.

12. Letter dated December 6, 1978, regarding an American Family claim; on file at the Division of Insurance.

13. Dr. Phillip Cole, Professor of Epidemiology, Harvard School of Public Health, interview, May, 1979.

14. Joseph Scotto and Leonard Chiazze, Jr., *Third National Cancer Survey: Hospitalization and Payments to Hospitals; Part A: Summary* (n.p.: U.S. Department of Health Education and Welfare, 1976), p. 115.

15. Letter dated July 7, 1977, regarding an American Income claim; on file at the Division of Insurance.

16. Letter dated July 24, 1978, regarding a Union Fidelity claim; on file at the Division of Insurance.

17. The policies of American Family and Washington National don't mention this consequence of the definitive treatment provision at all.

18. See *infra*, pp. 98 - 99, for discussion about the 70% figure.

19. Commonwealth of Massachusetts, Division of Insurance, *Market Conduct Examination Report of American Family Life Assurance Company of Columbus, Georgia* (Boston: By the Author, 1979), pp. 35, 42. The $1,278 figure in the text is the result of dividing $214,633.84 (total claims paid) by 168 (number of policyholders receiving claim payments).

20. Calculated from Union Fidelity computer print-out containing all Massachusetts cancer insurance claims reported during the period 1/1/77-8/31/78.

21. Commonwealth of Massachusetts, Division of Insurance, *Market Conduct Examination Report of the American Income Life Insurance Company* (Boston: By the Author, 1979), p. 6.

22. E. Paul Barnhart, "American Family," p. 6.

23. See Table 1 *supra*, p. 66. The cost of cancer insurance is rising rapidly, however, as new policies with greater benefits are introduced in response to medical care inflation. In December, 1978, American Family began filing with state regulatory authorities its new "X" cancer plan. Premiums on the X Plan range from $78 for individual coverage (with premiums on payroll deduction) to $144 for family coverage (with direct billing to the insured). (See American Family Corporation, Form 10-K for Fiscal Year Ended December 31, 1978, filed with the Securities and Exchange Commission, p. 7.)

24. The loss ratio presented in the text is called a cash or paid loss ratio. The incurred loss ratio is more precise and it relates incurred claims to earned premiums.

25. Commonwealth of Massachusetts, Division of Insurance, Market Conduct Examination Report of Union Fidelity Life Insurance Company (Boston: By the Author, 1979) p. __. The figure in the text was computed from the table after the non-cancer policies were excluded.

26. Commonwealth of Massachusetts, Division of Insurance, Market Conduct Examination Report of American Income, p. 2. This is a paid loss ratio; however, "it would appear that the paid loss ratio would approximate the incurred loss ratio over such a period."

27. Commonwealth of Massachusetts, Division of Insurance, Market Conduct Examination Report of American Family, p. 42. The figures in the text were computed from the table after the non-cancer policies (HIC-4) were excluded.

28. William O'Dell, California Insurance Department hearing transcript on File No. RH-204 relating to individual disability policies providing benefits for cancer only or dread diseases including cancer, September 27, 1978, p. 29.

29. Ibid., hearing exhibit number 6, pp. 21-23. The percentages for the fourth and fifth years are estimates based on the experience of policies issued before 1975.

30. Ibid., p. 29. The percentage for the fifth year is an estimate based on the experience of policies issued before 1975.

31. The anticipated loss ratio is really a weighted average that takes account of the time value of money. It is calculated by dividing the present value of expected future benefits by the present value of expected future premiums.

32. E. Paul Barnhart, "American Family," p. 2. The 56.09% estimate is based on the use of a 5% discount rate. Mr. Barnhart also computed a 64.74% estimate using a 0% discount rate. Mr. Barnhart presented the 56.09% estimate first, presumably because he felt it was more accurate given the significance of investment income to cancer insurance.

34. American Family Corporation, The American Family Story (Columbus, Georgia: By the Author, 1978), p. 25.

35. Although American's Family's policies are guaranteed renewable (i.e. the policy may be renewed for the lifetime of the insured at his option), the company retains the right to change the premium rate for all policies of the same form number. Moreover, in the words of the policy, "the Company has the right to make such changes by class without specific approval of any state authority." Policies of the other companies are similar.

36. Agency contract, form number AG-1140 SGA, p. 3. The 30% figure is in essence an average of the other two figures and is calculated in a manner similar to that presented for the anticipated loss ratio.

37. The Third National Cancer Survey (TNCS), conducted by the National Cancer Institute during 1969-1971, found that the average cancer patient incurred $2,529 in hospital costs over the first two years of cancer. (See Joseph Scotto and Leonard Chiazze, Jr., Third National Cancer Survey, p. 9.) In today's dollars, this represents an expenditure of about $4,500. (The Medical Care Consumer Price Index has increased about 80% between 1970 and 1978. See U.S. Bureau of the Census, Statistical Abstract of the United States: 1978 (99th ed,; Washington, D.C.: Government Printing Office, 1978) p. 491.) Based on available evidence regarding the pattern of cancer expenditures over time, this two-year figure, if rounded up to $5,000, can probably be viewed as closely approximating the lifetime cost figure. (The cost for the first three years of treatment approximates the lifetime cost of treatment. Also, in a sample of 45 patients, hospital costs fall off rapidly after the first year of treatment. See G. F. Vanderschmidt, J. Maloney, D. Wilson, The Measurement of the Cost of Cancer Care: Addendum to the Data Collection and Analysis Plan (Cambridge, Mass: Abt Associates, Inc., 1978), pp. 44, 45.)

Turning to non-hospital costs, the TNCS data also showed that the average cancer patient spent $1,571 in doctor and outpatient costs, or $2,827 in today's dollars. (See Jerry Cromwell, et al., The Measurement of the Cost of Cancer Care: Literature Review and Recommendations for Further Work (Cambridge, Mass: Abt Associates, Inc., 1976), pp. 55, 57.) However, unlike the TNCS hospital figure that reflects expenses over a two year period, this figure reflects expenses over widely differing periods of time. While most of the cancer patient interviews making up this average measured costs that were incurred from 6 to 18 months after the onset of cancer, some interviews measured costs for periods shorter than 6 months and other measured costs for periods up to 42 months. (See Ibid., p. 73.) Because of this variability, we will assume the actual lifetime doctor and outpatient cost figure is nearly twice as high, or $5000.

combining it with the $5,000 hospitalization figure produces an average lifetime cost of cancer of $10,000. This cost figure does not include cases of non-melonoma skin cancer, a common but highly curable -- and hence less expensive -- form of cancer.

38. The actual figure is 38%, which is the result of dividing 1.9 million (Massachusetts Blue Cross-Blue Shield's estimate of the number of people insured by this policy) by 5.05 million (the U.S. Bureau of the Census' 1970 estimate of the under 65 Massachusetts population).

39. The actual figure is 55%, which is the result of dividing 350,000 (Massachusetts Blue Cross-Blue Shield's estimate of the number of people insured under its Medex 1, Medex 2, Medex 3, and Medex Lo Option policies) by 636,000 (the U.S. Bureau of the Census' 1970 estimate of the 65 and over Massachusetts population). The Medex 3 policy is held by 290,000 persons. In combination with Medicare Parts A and B, it pays for 100% of the hospital charges for room and board and other services for 365 days. One hundred percent of the physician's fee for surgery is covered. Also covered in full are hospital outpatient charges for diagnosis, radiation therapy and up to 100 days of additional treatment following an inpatient admission of at least three days. Certain non-hospital outpatient charges are covered in full, including radiation therapy, diagnostic x-ray and laboratory services, and up to 100 days of doctors' treatment following a hospital inpatient admission of at least three days. In addition, skilled nursing facility charges for room and board and other services are covered in full for 100 days. Finally, 80% of the charges for prescription drugs used outside the hospital are paid for after a $25 deductible per calendar quarter.

40. John B. Amos, quoted in "Cashing in On Fear," p. 338.

40a. Commonwealth of Massachusetts, Division of Insurance, Market Conduct Examination Report of American Family, p. 35.

41. Joseph Scott and Leonard Chiazze, Jr., Third National Cancer Survey, p. 44. The 1970 numbers were increased by 80% to reflect that percentage change in the Medical Care Consumer Price Index between 1970 and 1978. (See U.S. Bureau of the Census, Statistical Abstract of the United States, p. 491.)

42. The typical policy also pays 100% of the hospital's charges for radiation therapy, up to a limit of $1,000. However, the exclusion of this benefit does not affect the results. Since radiation therapy is used in only 9% of hospital admissions and most of the cost of admissions is for room and board, including radiation therapy could not increase the payment percentages by even one percent. (See Joseph Scotto and Leonard Chiazze, Jr., Third National Cancer Survey, p. 115.)

43. *Ibid*.

44. *Ibid*., pp. 37, 44.

45. Commonwealth of Massachusetts, Division of Insurance, *Market Conduct Examination Report of American Family*, p. 35.

46. Joseph Scotto and Leonard Chiazze, Jr., *Third National Cancer Survey*, p. 115.

47. Computed from American Cancer Society, *Cancer Facts & Figures* (1979), (New York: By the Author, 1978), p. 10.

48. The cost figures were developed from Massachusetts Blue Shield 1977 data for surgeons' charges billed to Blue Shield. For procedures that had several forms of surgery, a weighted average was used. For example, mastectomy involved 11 procedures. For each, the number of procedures was multiplied by the fiftieth percentage cost; the resulting charges were summed and divided by the total number of procedures.

The payments expected from the typical policy correspond to the amounts that would be paid under each of the five policies providing surgical benefits.

49. Computed from Massachusetts Blue Shield 1975 data for the forty inpatient surgical procedures that were most costly in terms of aggregate payments made for all patients.

50. Commonwealth of Massachusetts, Division of Insurance, *Market Conduct Examination Report of American Family*, p. 35.

51. Jerry Cromwell, et al., *The Measurement of the Cost of Cancer*, pp. 55, 57. The 1970 numbers were increased by 80% to reflect that percentage change in the Medical Care Consumer Price Index between 1970 and 1978. (See U.S. Bureau of the Census, *Statistical Abstract of the United States*, p. 491.) The percentages in the second column were derived by dividing column five by column three.

52. It was assumed that surgery accounted for half the costs in the first category in Table 5.

53. Jerry Cromwell, et. al., *The Measurement of the Cost of Cancer*, p. 73.

54. National Cancer Institute, *Cancer Patient Survival*, pp. 152, 282.

55. Clair A. Snyder, Chairman of the Board of the Pennsylvania Division, American Cancer Society, "Testimony on Cancer Insurance," presented at the Pennsylvania Insurance Department's hearing on proposed regulations for individual accident and sickness insurance minimum standards, September 30, 1977, p. 5.

56. Commonwealth of Massachusetts, Division of Insurance, Market Conduct Examination Report of American Family, p. 35.

57. As discussed previously, 40% of the $2,000 estimate for total outpatient costs are not compensated at all by the cancer policy. If we assume that the remaining 60% of costs are all associated with chemotherapy and radiation therapy, then American Family's overall rate of compensation may be estimated at 40% (i.e., 0% times 40% plus 68% times 60%). Since some unknown amount of the 60% of costs are incurred for services other than chemotherapy or radiation therapy (and thus not compensated at all by the cancer policy), the rate of compensation is actually below 40%.

59. Dorothy P. Rice and Thomas A. Hodgson, "Social and Economic Implications of Cancer in the United States," a paper prepared for presentation to the Expert Committee on Cancer Statistics of the World Health Organization and International Agency for Research on Cancer at Madrid, Spain, June 20 to 26, 1978, p. 10. (Photocopied.)

60. American Family Corporation, Form 10-K, p. 20.

61. Beneficial Standard Life Insurance Company, policy form number 1-255-2.

62. Lincoln National Life Insurance Company, policy form number GR-108-2-77.

63. E.g., Lumbermans Mutual Casualty Co., policy form number IA5710; Mutual of Omaha, policy form number 45CM/CMF.

III. THE REGULATION OF CANCER INSURANCE

1. 211 CMR 40.05, 211 CMR 41.05 (marketing); M.G.L. c. 175, sec. 108(8)(A) (policy).

2. Idaho, Illinois, Massachusetts, Pennsylvania, Rhode Island, Washington, West Virginia. The following states may also be regulating

dread diseases specifically: Arkansas, California, Florida, Georgia, Kansas, Texas, Wisconsin. (See NIARS Corp., *Official N.A.I.C. Model Laws, Regulations and Guidelines* (2 vols.; Minneapolis: By the Author, 1979), vol. 1, pp. 120-24 - 120-25.)

3. The NAIC Model regulation defines "Specific Disease Coverage" as a policy which meets one of the following two definitions:

> (1) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of [$250.00] and an overall aggregate benefit limit of no less than [$5,000.00] and a benefit period of not less than [two (2) years] for at least the following incurred expenses: hospital room and board and any other hospital furnished medical services or supplies; treatment by a legally qualified physician or surgeon; private duty services of a registered nurse (R.N.); x-ray, radium and other therapy procedures used in diagnosis and treatment; professional ambulance for local service to or from a local hospital; blood transfusions, including expense incurred for blood donors; drugs and medicines prescribed by a physician; the rental of an iron lung or similar mechanical apparatus; braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease; emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and may include coverage of any other expenses necessarily incurred in the treatment of the disease.
>
> (2) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than $25,000 payable at the rate of not less

than $50 a day while confined in a hospital and a benefit period of not less than 500 days.

Ibid., p. 120-12.

4. West Virginia -- Administrative Regulation, Chapter.33-28, series XIII; Pennsylvania -- 31 Pa. Code 88.169.

5. New York -- 11 NYCRR 52.16(a); New Hampshire -- Insurance Department Regulation No. 19, sec. III(G)(1).

6. 692 C.G.S. 38-378.

7. John Sansone, principal examiner for the Connecticut Insurance Department, quoted in "Cashing in on Fear: The Selling of Cancer Insurance," Consumer Reports, June, 1978, p. 337.

8. Letter dated October 18, 1978, from Jerome Harleston, research attorney with the Office of Legislative Research of the Connecticut General Assembly.

9. New Jersey Insurance Department life and health circular letter no. 76-3, dated May 4, 1976.

10. Ibid.

11. "Cashing in on Fear," Consumer Reports, p. 337.

12. Ibid.

The Commonwealth of Massachusetts
Division of Insurance
100 Cambridge Street, Boston 02202

[redacted]
COMMISSIONER OF INSURANCE

February 5, 1979

NAIC Market Conduct Examination
and Reporting Committee
Honorable Richard L. Block
Director of Insurance
State Office Building
Juneau, AL 99881

Honorable Johnnie L. Caldwell
Commissioner of Insurance
238 State Capitol
Atlanta, GA 30334

Honorable Stephen F. Clifford
Commissioner of Insurance
100 Cambridge St.
Boston, MA 02202

Dear Commissioners:

The Commonwealth of Massachusetts Division of Insurance has conducted a limited Market Conduct Examination of the American Family Life Assurance Company of Columbus, Georgia. The examination concentrated on the company's cancer care and hospitalization indemnity policies.

American Family Life Assurance Company is a life, accident and health insurance company which solicits insurance through an agency force. The company's admitted assets and premium income at, and for the year ended December 31, 1977, are approximately $159 million and $203 million respectively. The premium income in Massachusetts for the year ended December 31, 1977 is approximately $375 thousand.

The examination team was composed of representives from Price Waterhouse & Co. who addressed those areas which required accounting expertise, William T. Baldwin Esquire, who addressed those areas which required legal expertise and R. L. Associates Inc., who performed market research activities.

The violations pointed out in this report must be corrected and the recommendations implemented. The company will submit to the Division of Insurance within sixty days of publication date of this examination report, a report stating how these violations have been corrected and recommendations implemented. New cancer expense policy and application forms and related promotional material must also be submitted within sixty days. The Legal Section of the Division of Insurance will consider the institution of disciplinary proceedings where appropriate.

Very truly yours,

Alan J. Wright
Director of Field Audit

AJW:elu

MARKET CONDUCT EXAMINATION REPORT OF AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS, GEORGIA

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Price Waterhouse & Co.

ONE FEDERAL STREET
BOSTON, MASSACHUSETTS 02110
617-423-7330

December 7, 1978

Mr. James M. Stone, Commissioner
Division of Insurance
The Commonwealth of Massachusetts
100 Cambridge Street
Boston, Massachusetts 02202

Dear Commissioner Stone:

In connection with the Division of Insurance's Market Conduct Examination of the American Family Life Assurance Company of Columbus, Georgia (the "Company"), we have completed the special work as set forth in our October 24, 1978 letter of mutual understanding which was agreed to on your behalf by Mr. Alan J. Wright, Acting Deputy Commissioner. Our responsibilities and the inherent limitations involved in our performance of the engagement are established in that letter. The procedures which we performed during the course of our work were adapted to meet the objectives of the Special Market Conduct Program.

We have no assurance that the work agreed upon is sufficient for the Division of Insurance's purposes and our work did not include many procedures, such as a review of internal accounting controls, which are essential for an examination of financial statements in accordance with generally accepted auditing standards. Accordingly, we do not express an opinion on the results of our work or give "negative assurance" with respect thereto.

For your convenience, we have summarized our comments on the more significant matters included in the accompanying report. Recommendations, where appropriate, are included in the text of our report.

A - Policy Forms and Marketing Brochures

1. The Company defines Massachusetts policies as those policies produced (sold) within Massachusetts by an agent licensed to do business in Massachusetts. Approximately 7.7% (1,010) of the policies held by Massachusetts residents consisted of several policy types that have not been approved by the Division of Insurance for use in the Commonwealth.

2. The Company has not complied with a Massachusetts Regulation which requires insurance companies to maintain signed acknowledgments that each insured was provided with the appropriate disclosure notice at the time the policy is applied for. There is no evidence that the Company's agents have delivered the required disclosure forms to applicants.

B - Agency Relations, Training and Terminations

1. Associates (agents) work under formal contracts with the Company which provide for commissions and other sales incentives only (non-salaried); they are not required to work full time for the Company. Recruiting is primarily the responsibility of the state and district managers, who are also commission-compensated associates. The Company and the state manager have no character investigation reports on file for thirty-three of the fifty-nine active Massachusetts agents as of June 30, 1978 and personal history information could not be located for four of the active agents.

2. Six Massachusetts policies were written by three unlicensed (at the time of policy issue) agents in 1977; the Company instituted new procedures in 1978 to prevent this problem from recurring.

3. All marketing materials (primarily letters used within franchise groups) used in Massachusetts are not being submitted to the Company's home office for review, approval and control as required by Massachusetts regulations.

C - Policy Applications

1. The results of our statistical sample of policy applications indicated that Company procedures for issuing the policy types which were applied for by Massachusetts insureds during the period tested were at the proper application premium rates and payment modes.

D - Complaints and Policyholders Services

1. The Company does not maintain records as to the type of inquiries and complaints received from policyholders for summarization and review by upper management. Inquiries and other policyholder requests required an average of 16 days for resolution.

2. Complaints from thirteen policyholders involving twenty separate claim matters resulted in additional payments by the Company to the insured in six instances.

E - Claims

1. The rate of incurred claims to earned premiums for Massachusetts policies for the period January 1, 1977 through June 30, 1978 was approximately 42%.

2. The Company's reports, from which cumulative benefit-to-charges ratios are compiled, were found to be unreliable. Our Massachusetts claims sample reflected an accumulated ratio of 23.4% of benefits paid to charges incurred and submitted to the Company by the insureds; additional charges may have been incurred by the insureds but not submitted to the Company, in which case the ratio would be lower.

3. Our testing indicates that Company procedures were unacceptable (i) to assure payment of benefits in accordance with the terms of the policy and (ii) to assure that letters sent to insureds, are complete as to what additional benefits are available.

4. It takes the Company an average (based on Massachusetts sampled claims) of 6.4 days to pay a claim once all necessary claims documents have been received.

* * * * *

We are pleased to report that the Company imposed no restrictions on the method or extent of our work and we were given access to all records and other supporting data which we requested. Full cooperation was received from the officers and employees of the Company with whom we dealt.

This report is solely for the information of the Division of Insurance and should not be used for any other purpose without our permission. The report should not be associated with the financial statements of American Family Life Assurance Company of Columbus.

Yours very truly,

Price Waterhouse & Co.

A. - POLICY FORMS AND MARKETING BROCHURES

1. Listing and review

The policy types and corresponding marketing brochures used by the Company in Massachusetts, relative to 'dread disease' and other limited supplemental (intensive care) coverages, are identified in Exhibit A-I to this section. Copies of each of the forms and brochures were provided to the engagement attorney for subjective analyses of wording, understandibility and compliance with Massachusetts regulations. The Company's primary product is cancer insurance which is sold in 47 states and several foreign countries (particularly Japan). The following reflects cancer policies in force in Massachusetts as compared to cancer policies in force nationwide over the past several years:

Year	Nationwide	Massachusetts
1974	1,510,018	3,387
1975	1,797,646	6,631
1976	2,107,655	8,025
1977	2,411,490	8,421
July 31, 1978	2,621,259	9,053

Massachusetts policyholders constitute a comparatively small portion of the Company's volume, but the Commonwealth is considered by the Company's State Sales Manager to have the potential to yield outstanding sales growth for the next several years. The intensive care policies marketed by the Company in Massachusetts have been immaterial as compared to its cancer business, but have been increasing in recent years. A few hospitalization and whole life insurance policies have been marketed in Massachusetts which are not listed in Exhibit A-I as those types of coverage were not within the scope of our work.

2. Inclusiveness of listing

Our tests to determine that all policy forms and marketing brochures used in Massachusetts were provided to us included substantial reference to claims and policyholder (by writing agent) detail listings to observe policy type codes. Reference to detail listings, particularly a special policyholder listing prepared for us of all policyholders with Massachusetts ZIP codes, revealed that 1,010, or 7.7%, of all policies held by Massachusetts residents during the period January 1, 1977 through June 30, 1978 consisted of several policy types which have not been approved for use in the Commonwealth.

We recognize that insureds who purchase policies elsewhere move to Massachusetts and some insureds purchase coverage through out-of-state employers by payroll deductions; however, a considerable question as to definition of a 'Massachusetts policyholder' may exist in other instances. Company officials define Massachusetts policies as "only those policies produced (sold) within Massachusetts by an agent licensed to do business in Massachusetts."

We selected several policies from the non-approved types appearing most frequently on the detail ZIP code listing and obtained the policy applications and agent transmittal forms. The results of our review are summarized as follows:

(a) 276 type BD policies (certificates) and 102 type L4 policies (certificates) were sold to alumni of Brandeis University through the Brandeis University National Women's Committee under group insurance policy GP-465 H. The Company provided to us a copy of the letter (on Brandeis University National Women's Committee Stationery - printed by American Family Life Assurance Company) dated December 1974 from the Women's Committee to its members endorsing the coverage and a copy of the application for group coverage (undated) filed by Mrs. Solomon Stern, Brandeis University National Women's Committee whose main office address is Waltham, Massachusetts. A Company official stated that the Brandeis policy is not a Massachusetts policy because it is sold by a Texas agent. Examination of several applications and agent transmittals indicates business is produced in Massachusetts. The Texas agent is also licensed as a non-resident Massachusetts agent. The Company provided a letter dated

August 26, 1971 from the Division of Insurance stating that policy form CMP-2 was placed on file inasmuch as there is no authority under the provisions of Section 110 of Chapter 175 of the General Laws of the Commonwealth for approval of said form.

(b) Massachusetts was not assigned as the state of issue for 8 policies sold from the Company's home office in Columbus, Georgia to Massachusetts residents. Other policy applications reviewed appeared to properly reflect state of issue other than Massachusetts.

(c) 199 type X3 policies were marketed, apparently by mail, to members of the Post Office Association. Transmittals indicate policies are sold in Washington, D.C.

3. Approval

For each policy form listed in Exhibit I, the Company provided to us copies of letters of approval from the Division of Insurance or of letters of transmittal from the Company to the Division of Insurance, with 'Deemed Approved' having been written thereon by a Company official under the "no response within 60 days" regulations.

4. Ten day return

No records are maintained of the number of insureds returning their policies under the "10 day free look" provision. Discussion with the Operations Officer indicates the number of policies returned under the provision is minimal. However, there is another category of 'immediate lapse' which constitutes approximately 3% to 4% of all policies issued by the Company. These lapses result when participants in a payroll group advise their payroll clerk, prior to the initial remittance, that they do not want the payroll deductions to begin. The Company is not notified of this change in advance and does not receive premiums on the policy. The lapse date in these circumstances is the same as the issue date.

5. Policy and brochure development

The Company's policy is to maintain a complete file of brochures and other marketing materials used in each state (see Agency section for discussion and exceptions). The brochures, which also serve as the policy application, are distributed by the Company's agents. The Company's Compliance Officer explained that there are no marketing studies, surveys or memoranda which led to development of the policies or brochures available because the Company originated cancer insurance several years ago and significant changes in policy types have not occurred for many years. Brochure representations as to statistics come almost entirely from Cancer Facts & Figures, an annual publication of the American Cancer Society, Inc. The Company provided to us a letter from the American Cancer Society, Inc. stating permission to use information from the 1975 Cancer Facts & Figures.

We compared the statistical information in the marketing brochures to the Cancer Facts & Figures noting some minor exceptions which are presented in Exhibit A-II.

6. Disclosure forms

Section 14 of Massachusetts Regulation 2-74 requires that insurance companies maintain signed acknowledgements from each policyholder that the insured was provided with the proper disclosure notice at the time the policy was applied for. The Company has failed to maintain evidence on file that the agent delivered the required disclosure forms for substantially all business written in Massachusetts.

The Operations Officer stated that his review indicated that a breakdown in procedures occurred because of internal failure to notify the Company's new business section that the signed acknowledgements would be required to process Massachusetts applications. Consequently, only a small percentage of applications accepted since 1974 have had the applicants' signed acknowledgements that the proper disclosure statement was provided.

EXHIBIT A-1

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS

CANCER AND INTENSIVE CARE POLICY FORMS USED IN MASSACHUSETTS

Policy Form No.	Policy Types	Sales Brochure and Application Form No.	Period of Use	Sales Type	Plan Code	Total policies in force at any time during the period 1/1/77 to 12/31/77	Total policies in force at any time during the period 1/1/78 to 6/30/78	1977 Earned Premium	1978 Jan.-June Earned Premium	1/77-6/78 Total Earned Premium	Individual-I Family-F	Annual Premium Rates
FIC-1 with A4482A	Cancer-with scheduled benefits in policy	None	Through 9/71	Direct sales	D1	192	181	$ 7,355.97	$ 3,521.49	$ 10,877.46	I F	$30.00 50.00
				Payroll groups	D2	178	170	5,336.99	2,269.72	7,606.71	I F	22.00 36.00
				Associations	D3	123	118	3,882.65	1,868.03	5,750.68	I F	23.00 37.00
MIC-4 and intensive care-$100/day MIC-4 (revised) hospitalized in ICU MIC-4 (revised) intensive care-$130/day with A6536 hospitalized in ICU		A5849 A6581 A6582 A7302-7304	Through 9/74 9/74-present 9/74-present 10/75-present	Direct sales	M9	189	232	2,284.00	1,988.50	4,272.50	I F	12.00 24.00
				Payroll groups	M6	277	814	4,159.86	4,691.91	8,851.77	I F	12.00 24.00
A4474	Cancer-with scheduled benefits in policy	A4475 A6375	Through 3/74 3/74 - 5/74	Direct sales	R1	279	257	13,725.92	6,510.11	20,236.03	I F	40.00 60.00
				Payroll groups	R2	1,189	1,119	47,093.32	21,606.80	68,700.12	I F	30.00 45.00
				Associations	R3	584	543	25,404.05	12,059.86	37,463.91	I F	33.00 50.00
A6021	Cancer-with scheduled benefits in policy	A6437 A6437 A7302-A7304 A7011	5/74-present 11/74 - 4/75 10/75-present 4/75-present	Direct sales	W4	3,343	3,081	110,999.79	67,125.74	178,125.53	I F	40.00 60.00
				Payroll groups	W5	2,389	2,639	80,167.61	39,830.01	119,997.62	I F	30.00 45.00
				Associations	W6	1,439	1,209	55,361.01	25,363.37	80,724.38	I F	33.00 50.00
A8011	Cancer-$100/day first 90 days hospitalized; $200/day thereafter	A8195	6/21/78-pre.	Direct sales	C-D						I F	50.00 75.00
				Payroll groups	C-E						I F	42.00 57.00
				Associations	C-F						I F	45.00 62.00
						10,182	10,363	$355,771.17	$186,835.54	$542,606.71		

EXHIBIT A-II

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS

POTENTIAL MISSTATEMENT OF THE AMERICAN CANCER SOCIETY'S CANCER STATISTICS IN THE COMPANY'S MARKETING BROCHURES

Brochure Number	Statement in Company Brochure	Statement in Cancer Facts and Figures
A8195	88,000 women will develop breast cancer this year... Source: '76 Cancer Facts and Figures - American Cancer Society.	
A6437	326,000 men will develop cancer this year... Source: '74 Cancer Facts and Figures - American Cancer Society.	The 1974 and the 1976 Cancer Facts and Figures state on pages 9 and 11, respectively, that the estimated number of cases are estimates and "are offered as a rough guide and should not be regarded as definitive."
A7011 A7302 A7303 A7304	326,000 women will die this year from breast cancer... Source: '74 Cancer Facts and Figures - American Cancer Society.	
A6437	89,700 women will develop breast cancer this year.	The 1974 Cancer Facts and Figures, page 10, shows estimated new cases of breast cancer for both men and women at 89,700. For women alone, the estimate was 89,000.
A6437	Lung cancer in men has increased 1500% since 1930.	The 1974 Cancer Facts and Figures pages 5 & 18 indicates the rate of incidence for men's lung cancer to be 14 times greater than 40 years earlier (not 1500%).
A6195	Cancer is the leading killing disease of children ages 4-14.	The 1976 Cancer Facts and Figures, page 6, states "cancer is responsible for more deaths in the 3 to 14 year old group..."

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December 19, 1978

Mr. James M. Stone, Commissioner
Division of Insurance
The Commonwealth of Massachusetts
100 Cambridge St.
Boston, MA 02202

Dear Commissioner Stone:

In connection with the Division of Insurance's Market Conduct Examination of the American Family Life Assurance Company of Columbus, Georgia (the "Company"), I have completed those portions of the Special Market Conduct Examination Program that were designated as being the attorney's responsibility or the responsibility of both the attorneys and the auditors. The procedures followed were adapted to meet the objectives of the Program. The primary emphasis of this report is placed upon the manner in which the Company's policies and practices can be changed to ensure protection for the consumer, guided by the principles and provisions of Massachusetts laws and regulations regarding unfair and deceptive trade practices (Chapter 93A), and the Massachusetts insurance laws (Chapters 175 and 176D).

For your convenience I have summarized my comments on the more significant portions of the report.

A - Policy Forms and Marketing Brochures

1. The brochures used in selling cancer insurance appear to be inadequate, deceptive and misinformative. The incidence and cost of cancer, rather than the benefits or coverages, are used as the primary selling tool. The description of benefits payable fails to provide sufficient relevant information about the policy. The brochures also fail to disclose some of the limitations in the policy and the likelihood that coordination of benefits by other policies will apply.

2. The two policy forms which are analyzed in detail are the "CancerCare" and the Cancer Hospitalization Indemnity Policies. Both policies are in apparent violation of statutes and regulations by virtue of their format and definitions or lack thereof when such definitions are required to be stated or are prescribed by regulation. Further, these policies provide for increases in premium in an apparent violation of the regulations which prohibit such increases for specified disease policies. These policies should be reviewed and recommendations for changes made.

3. A group policy of insurance has been sold to an organization in such a manner that it does not qualify as a group policy under the definition provided by Massachusetts law. These issuances are therefore of individual policies of insurance, which have not been reviewed by the Massachusetts Division of Insurance. Certificates of insurance under this policy are marketed nationally, based upon the premise that they are issued pursuant to a Massachusetts group plan.

4. Individual policies of insurance have been sold by direct mail to Massachusetts Postal Workers. This is not a group policy, nor has the policy form been submitted to Massachusetts for approval. The selling agency is not licensed to do business in Massachusetts.

5. The extended benefits provision contained in the policies, which provides increased benefits for more than 90 consecutive days of hospital confinement is illusory, as actual results show that rarely, if ever, do persons hospitalized for cancer spend more than 30 days in the hospital, while the average is 9 days. The consumer is not informed and has no way of knowing how unlikely he is to collect under this provision.

6. The policies are subject to coordination of benefits by major medical group insurance. A large proportion of policyholders have major medical group coverage for which this would be the case.

7. The policy is a high markup, low value item. Commissions range from over 50% to a low of 13% of first year premiums, and the loss ratios are less than 50% overall. The Company policy has been to increase premiums when loss ratios exceed 50%.

B - Agent's Licensing and Training

1. The Company's sales training program appears to be deceptive and utilizes high pressure, low information techniques. Training conducted for purposes of the State licensing examination appears to be woefully inadequate. All training for the licensing exam and most of the sales training is conducted by commissioned salesmen in the field. No records of attendance or performance are kept by them. The sales technique taught is subject to many of the same shortcomings as the policy sales brochures. It overemphasizes the incidence and cost of cancer, while not providing sufficient relevant information regarding benefits.

2. Past practices of the Agent's Licensing Department appear to have been inadequate. Recently instituted procedures of that department show an improvement in the manner in which applications are examined, and qualifications and references are checked out. These newly instituted procedures should be followed and applied to all phases of record keeping and follow-up in that department.

C - Sales Practices

1. Sales are conducted primarily by agent selling, either to cluster groups or individual purchasers at home. Leads are obtained by approaching employers and organizations, or by scanning voter lists for the elderly. The use of peer pressure and the express or implied endorsement of employers, associations or friends is a standard part of the sales technique.

2. The Company does not regulate sales practices. Agents have created sales materials and practices on their own, without company supervision, although the Company was aware that the agents were doing so. Some of the materials used by agents to represent claim payments made in the past and to explain away the coordination of benefits problem constitute misstatements of the policy benefits and drawbacks.

D - Complaints, Policyholders Services

1. The Company's system of Complaint handling does not utilize sufficient record keeping procedures to allow for company analysis of problem areas or to comply with the record keeping requirements of Massachusetts laws.

G - Claims

1. Errors of omission are found to be at an unacceptable level in the claims handling department. While the turnaround time for claims handling appears satisfactory, more supervision and possibly automation of the clairs handling proedures are necessary to ensure complaince with ch. 176D.

Very truly yours,

William Y. Baldwin
Marullo, Baldwin, Frieden,
Gatewood & Lindner
141 Tremont St.
Boston, MA 02111

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A. - POLICY FORMS AND MARKETING BROCHURES

1. RESULTS OF EXAMINATION OF POLICY SALES BROCHURES

The policy sales brochures examined are used in selling two types of cancer policies, the A-6021, Cancer Policy with a schedule of benefits and the A-8011, Cancer Hospitalization Indemnity Insurance. The following brochure numbers were examined by application of the Marketing Materials Examination Checklist portion of the Market Conduct Examination Program:

BROCHURE NO.	POLICY TYPE	OTHER POLICIES MARKETED IN THE SAME BROCHURE
A-8195	Hospitalization Indemnity Plan, A-8011	NONE
A-6437	CancerCare, A-6021	NONE
A-7302] 7303] 7304]	CancerCare, A-6021	[Hospital [Intensive Care [Plan A-4696
A-7011	"CARE PROGRAM" CancerCare A-6021	Hospital Intensive Care A-4696 and Life Care A-5191

Sales brochures play a very important role in the Company's sales program. Virtually all of the Company's sales are made through agent selling, both door to door and by cluster selling to employment related or other groups. The agent's primary selling tool, other than his sales pitch, is the brochure. The agent may stamp the brochures with his or her name, address, and phone number, and leave them with purchasers.

A common theme which exists throughout all of the brochures examined is the use of a "Cancer Will Strike" sheet. This "strike sheet" uses silhouetted figures to show women, children, families and people in general to illustrate cancer statistics. Beneath each silhouette or group of silhouettes is a statement of cancer statistics, citing the American Cancer Society's report, Cancer Facts and Figures. All of the cancer brochures now in use in Massachusetts make use of the "Cancer Will Strike" sheet.

The next common theme is some form of presentation regarding the debilitating costs of cancer treatment. Fear of the cost of cancer may be the single most significant factor in influencing individuals to purchase this insurance. In evaluating the specific harm that arises from an appeal to the emotions, it must be remembered that such appeals do not lead the consumer to make a decision upon a rational basis. It is a more reasonable position to state that the monetary cost of cancer is to be guarded against, but the statements regarding the cost of cancer are not very specific, ranging from "Cancer is Getting More Costly" (Brochure A-7302), to a discussion of the "economic considerations of cancer treatment" (Brochure A-8195). The only statistics cited in brochure A-7302 are for the overall cost of cancer treatment nationwide, 1962 to 1972. Similarly, the "Economic Considerations" approach contains considerations that apply equally as well to any type of disease. The considerations cited are indirect expenses, travel to another city for treatment, and disability of a wage earner. The most important consideration for the customer buying insurance is that he make a rational decision based upon the facts. The economic argument set forth in the brochures, which bears no more relationship to cancer than to any other type of illness or injury, is not relevant.

The primary emphasis in the Company's policy brochures is on the above-described elements of cancer incidence and health care costs. In each brochure there is also a section describing the contents of the policy; the basic benefits, extended benefits and the limitations and exclusions contained in the policy. The schedule of basic benefits in the brochures states that the surgical benefits are "The fee charged to amount shown in schedule and policy. Hospitalization not required. Limit $50-$500. No limit on the amount of operations." (Brochure A-7303) This would indicate to most readers

4 that the policy pays for the cost of surgery up to $500, which it does not. In order to determine what the policy will pay on any specific procedure performed, one has to refer to the policy's "Schedule of Operations," which appears in the policy itself. A closer analysis of that schedule reveals that $500 will be paid for only 4 of the 34 operations described. This schedule is not long and it could be easily included as part of the brochure without eliminating any other useful information. In order that the consumer may make an informed evaluation of the policy, it should be stated what costs are likely to be incurred that are not covered by the policy. Otherwise, a buyer might feel that the schedule of benefits is comprehensive. Blue Cross-Blue Shield of Massachusetts uses this approach in the brochures describing their MEDEX policies. Bar graphs indicate the expenses which are covered by the MEDEX Medicare supplement policy, and those remaining to be paid by the individual.

Another informative approach would be for the policy brochure to explain what percentage of total medical costs the Company's policy will pay on the average. 4 The random sample of claims selected by the auditors reveals that the Company did in fact pay an average of 23.4% of charges.

The Company's advertising material fails to mention that the policy benefits may be subject to coordination by other policies of insurance. Brochure form A-6437 contains a section dealing with coordination of benefits which states:

OTHER INSURANCE

> This policy is intended to supplement your existing health insurance program to better provide for the unusual expenses of Cancer; therefore, the policy contains no provisions reducing benefits because of Medicare or any group or individual insurance you may carry. However, only one policy on this plan will be issued to any individual.

Under Massachusetts General Laws ch. 93A, §2 and the Attorney General's Regulations, it is incumbent upon one who is selling a product or service to disclose all relevant information to the consumer which he would need to make a rational, informed decision.

The regulations promulgated under ch. 93A have held that the seller cannot protect himself from charges of unfair or deceptive practices by merely remaining silent. Instead, the failure to disclose facts which, if known to the buyer, would have influenced him not to buy constitutes an unfair and deceptive trade practice and therefore is a violation of that statute.[1] The Company fails to make such disclosure on any of its policy brochures. Brochure A-6437 broaches the subject of coordination. In the section quoted above, the brochure tells a half-truth, thereby misrepresenting the value of the policy. When it states that the policy does not coordinate benefits, it should also state whether the opposite is true, whether it may be coordinated against. The latter information is just as relevant as the former.

Brochure form A-7011 is entitled "CARE PROGRAM, a supplement to your present health and life insurance." It seels three policies, "Cancer Care (A-6021), "Intensive Care" (A-4696) and "LifeCare" (A-5191)." The overall format of the brochure suggests that these three policies, when taken together, fully supplement the consumer's present health and life insurance. The consumer who buys the whole package may construe its coverage in the normal sense, thinking that it picks up where his other Major Medical leaves off, while in fact it only provides benefits for cancer, time spent in an intensive care unit, or death. Thus, brochure form A-7011 tends to be misleading.

The use of the above described brochures constitutes an apparent violation of ch. 93A, §2. By excessive appeals to the emotions aroused by the fear of cancer and its costs, and the failure to clearly outline the benefits and drawbacks of the policy, consumers are induced to buy without the facts necessary for a rational decision. The misleading reference to coordination of benefits stands out as an obvious violation of that section. Interviews with insureds reveal that they have retained more information about the incidence and cost of cancer than about the benefits provided by the policy.

The following recommendations are made in order that the brochures not be misleading and provide more useful information to the consumer:

1. Eliminate the "Cancer Will Strike" sheet on all policies;
2. Disclose the existence of coordination of benefits provisions

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[1] Attorney General's Consumer Protection Act (ch. 93A) Regulations dated July 1, 1971, section XV B

that are contained in Massachusetts' master medical plans;

3. Eliminate use of the "Care Program" brochure, and
4. Disclose benefits in such a way that the consumer may evaluate the benefits before filing a claim.

2. POLICIES

a. CANCERCARE

Policy form A-6021 is a cancer policy with scheduled benefits, known as the "CancerCare" policy. It has been sold in Massachusetts from May 1974. As it is the primary policy sold by the Company in Massachusetts, it is the policy by which the value of the Company's scheduled benefits may be judged most accurately.

The schedule of benefits for policy A-6021 is set forth in parts 1 and 3 of the policy. The limitations in the policy are as follows:

(1) Waiting period of 90 days.

(2) Extended benefits are not to exceed $5,000.00 per month.

(3) When cancer is diagnosed subsequent to treatment, but while the insured is living, benefits are payable beginning with the later of:
   (a) the first day of hospital confinement during which such diagnosis is made, or
   (b) ten days prior to diagnosis.

(4) When cancer is discovered by post-mortem diagnosis, benefits are payable beginning with the later of:
   (a) the date of terminal admission, or
   (b) 45 days prior to death.

(5) A positive pathology report is required, clinical diagnosis is not sufficient.

(6) The policy covers cancer only.

(7) The policy does not pay for treatment in Veteran's Hospitals, rest or rehabilitation homes, mental institutions, sanitariums, nursing, convalescent homes or other extended care facilities.

The policy marketing brochures and sales approach fail to reveal the existence of limitations numbered (3), (4), (5) and (7). Such failure to disclose a material fact constitutes an apparent violation of ch. 93A, §2.

The following apparent violations of Insurance Regulation 2-74 are found to exist in policy form A-6021:

(1) Regulation section 5, paragraph 14 requires an understandable explanation of the term "usual and customary" to be stated where such term appears in the policy. "Usual and customary" is used in the policy to define extended benefits, radiation and chemotherapy, blood and plasma and ambulance charges, without an accompanying definition.

(2) Regulation section 5, paragraph 19 requires a "pre-existing condition" section to be labelled as such and printed on the first page of the policy. No such heading is used to describe the preexisting condition established in part 1A of the policy.

(3) Regulation section 5, paragraph 32 requires that for all specified disease coverage the policy premium shall not be subject to premium increases. On page 4 in the section entitled "Renewal Provision," the Company retains the right to raise the premium for all policies of a type within the state upon 30 days notice to the insured.

(4) Under the basic benefits section the policy defines "continuous confinement" as discharge and readmission within 30 days. Under the Extended Benefits section there is no applicable definition. Regulations section 6(A) requires the definition to state that discharge and subsequent admission for the same cause may occur within 90 days and still qualify as continuous confinement.

Policy form A-6021 also contains an apparent violation of Chapter 175, §108, part 2(a)(5) which requires that all exceptions and reductions are to be collected under one heading labelled either "Exceptions" or "Exceptions and Reductions." There is a section labelled "EXCEPTIONS AND LIMITATIONS," but it does not contain the post-mortem diagnosis, VA Hospital, and other exceptions or reductions contained elsewhere in the policy.

b. HOSPITALIZATION INDEMNITY PLAN

Policy form A-8011 is a Cancer Hospitalization Indemnity Policy. It was deemed approved in Massachusetts, effective 12/30/76 and a brochure was developed by 6/21/78, and as yet there are few policies outstanding. A-8011 is the policy designed to avoid the problems resulting from coordination of benefits by other policies. It seeks to achieve this result by indemnifying the claimant, not for any specific line items of insurance, but by payment of a sum based upon the number of days the claimant is hospitalized.

Policy A-8011 pays $100 per day, not to exceed $3,000 per month, for continuous periods of hospital confinement up to 90 days. Over 90 days, the Company pays $200 for each day of continuous hospital confinement. The primary limitations in this policy are:

1. The requirement that confinement be continuous for 90 days for extended benefits to apply,
2. The 60 day waiting period,
3. A positive pathology report is required, clinical diagnosis is not sufficient,
4. When cancer is diagnosed subsequent to treatment, but while the insured is still living, benefits are payable beginning with the later of:
   (a) the first day of hospital confinement during which such diagnosis is made, or
   (b) thirty days prior to diagnosis.
5. When cancer is discovered by post-mortem diagnosis, benefits are payable beginning with the later of:
   (a) the date of terminal admission, or
   (b) 45 days prior to death.
6. The policy does not pay for the treatment in Veteran's Hospitals, rest or rehabilitation homes, mental institutions, sanitariums, nursing or convalescent homes or other extended care facilities.

The following apparent violations of Insurance Regulation 2-74 are found to exist in policy form A-8011:

(1) The policy provides that the premium may be raised by policy type, statewide, upon 30 days notice to the insured. This is an apparent violation of Regulation 2-74, section 5, paragraph 32, which prohibits such increase for specified disease policies.

(2) There is no definition of "continuous hospital confinement" as is required by Regulation 2-74, section 6(A).

Policy form A-8011 also contains an apparent violation of Chapter 175, § 108, part 2(a)(5) which requires that all exceptions and reductions are to be collected under one heading labelled "Exceptions and Reductions."

c. "BRANDEIS" POLICY

Policy A-4797, also known as policy CMP-2, is written as a group insurance policy. It was submitted to the Massachusetts Division of Insurance in August of 1971. The head policy form analyst declined to approve or reject form CMP-2, inasmuch as it appeared to be a group policy, and there is no authority for the approval or rejection of such policies under the provisions of M.G.L. ch. 175, §110. Form A-6795, also known as form CMP-2 Certificate, is the certificate issued to the individuals insured under policy CMP-2. There is no indication that this form was ever submitted to the Massachusetts Department of Insurance. Policy CMP-2, together with the certificate, has been issued to the Brandeis University National Womens Committee as a group. With the endorsement of that organization the policy is marketed to organization members in several states. Massachusetts General Laws ch. 175, §110 provides that a group insurance policy qualifies as a group plan only if it is issued within certain guidelines. This statute contemplates groups in which the employer is paying the premium for employees or employment-related groups, or associations insuring not less than 75% or not less than 8,000 members, where such members pay all or part of the premium themselves. The policy as issued is therefore not a group policy of insurance pursuant to M.G.L. ch. 175, §110. Its issuance without approval as an individual policy is an apparent violation of § 108 of that chapter.

d. POSTAL WORKERS POLICY

Pennsylvania FIC-2A and FIC-2 policies have been issued to Massachusetts Postal Workers who are members of the "Post Office Assocation." Presently there are 226 of these policies outstanding in Massachusetts. The wide variety of locations in which these policies are sold, as evidenced by inspection of one new business transmittal, indicates that the applicants were reached by direct mail from an office located in the District of Columbia. All of the issuances of the Post Office Association Policies were dated in 1970 or 1971, and due to lapses the number outstanding today is smaller than was originally the case.

Policy form FIC-2A and FIC-2 have not been submitted for approval in Massachusetts. It is generally accepted that where a group policy is approved in one state the law does not require further approval by the insurance commissioner of each state in which certificates of insurance are issued. However, these policies do not qualify as group policies under ch. 175, §110. The sale of such individual policies of insurance within the Commonwealth without prior approval is an apparent violation of ch. 175, §108.

3. GENERAL COMMENTS

a. EXTENDED BENEFITS

With respect to all policies paying extended or increased benefits after 90 days of continuous confinement (all of the policies discussed above do so) such benefits are illusory because of the short average duration of the cancer victim's stay in the hospital. From an anaysis of 1 of every 5 Massachusetts paid cliams and 35% of claimants who were paid during the subject period (1/1/77 - 6/30/78), no claim resulted in payment of extended benefits to the policyholder. The average number and median number of days of confinement for each claim is 9 days, and the average confinement period for all in-patient claims is 13.2 days. A stratification of the claims selected illustrates that of the 85 claims examined, no claimant qualified for extended benefits. In fact, none of continuous confinements exceeded 90 days, and in only one case did confinement exceed 30 days.

This is a material fact relating directly to the value of the benefit in the policy which is used as a selling point. Use of such an illusory benefit tends to be deceptive and therefore constitutes an apparent violation of ch. 93A, §2.

b. COORDINATION OF BENEFITS

(1) EXPLANATION OF THE PROBLEM

Coordination of benefits is the process by which an insurer will reduce or eliminate his liability for reimbursement of a specific line item cost because that particular line item is also covered by another insurance policy. American Family sells its insurance on the principle that their coverage may very well exceed the gap left by other medical coverage. This is said to be desirable because of the costs of illness that are not represented on the hospital bill, such as lost wages, travel expenses, and so. Assuming that a person is hospitalized for one day with room charges of $180, an ambulance charge of $50 and surgical expense of $250, and assuming that this person is covered by Dread Disease and Major Medical coverage, coordination of benefits might apply as illustrated in the following chart:

Line Item Expense	Actual Cost	The Company's Coverage	MAJOR MEDICAL COVERAGE Without Coordination	MAJOR MEDICAL COVERAGE With Coordination
Room Charge	$180	$ 50	$100	$100
X-ray	50	50	20	0
Surgical	250	100	250	150
	$480	$200	$370	$250

Total cost..$480
Total coverage if coordination applies $450
Total coverage if coordination doesn't apply.......................$570

Some points become evident from the above analysis:

(a) Although the insured has insurance in excess of the actual cost, coordination of benefits acts to reduce that coverage below the actual costs.

(b) $200 worth of Dread disease coverage reduces the insured's Major Medical coverage benefits by $120.

In most states group policies are not permitted to coordinate against individual or franchise policies. The Company's policies are, with few exceptions, individual or franchise policies. The Company only deals with the matter of coordination when it becomes a problem. Nothing has been done with respect to Massachusetts, partly because in Florida, the Company litigated the matter of other companies coordinating against the CancerCare policy. The Court declined jurisdiction in favor of the insurance commissioner's administrative jurisdiction over insurance matters. The Company has also waited in anticipation of the passage of new legislation. Massachustts' legislature has twice passed a bill that would prohibit coordination of benefits by all policies, but each time it was pocket vetoed. Massachusetts' State Manager claims that coordination has cost him 60 to 80 agents because other companies have stated that they would coordinate against the Company's policies when this becomes know, it discourages sales or causes policy cancellations. It is this spectre of coordination that poses a problem to the Company. As a practical matter, the fact that the Company pays directly to the insured, rather than to the hospital or doctor, enables the insured to avoid letting his Major Medical insurer know that he has other coverage.

The Company has responded to the problem in other states by attaching a CHIP (Conversion to Hospital and Indemnification Plan) rider to a policy that is the equivalent of Massachusetts' CancerCare (A-6021) policy. This is seen as a solution to the coordination problem because the converted A-6021 Type policy is then, in effect, the equivalent of the hospitalization indemnity plan (A-8011 in Massachusetts). The A-8011 is'a hospitalization indemnity plan which pays benefits solely on the basis of the number of days that the insured spends in the hospital. It is argued that such a policy cannot be coordinated against becasue it does not reimburse for any line items as such.

(2) MASSACHUSETTS STATUTES

Massachusetts General Laws ch. 175, §108, which provides that individual policies may coordinate benefits only if a pro rata reduction in premium is made in conjunction with coordination. Ch. 175, §110, which deals with group insurance, contains no such restriction as to coordination, and also exempts general or blanket (group) policies of insurance from the provisions of §108. This means that individually sold Major Medical polices may not coordinate unless they choose to calculate a pro rata redemption of premium when such coordination is effected, while Group insurance policies are under no such restriction. Some states have required all insurance sold, group or individual, to refund a pro rata portion of the premium. Where such is the case, the Company has no real problem with coordination, because it costs more for other companies to comply with the pro rata redemption requirement then they would save by using the privilege.

(3) BLUE CROSS-BLUE SHIELD POLICY COORDINATION PROVISIONS

In the survey conducted in conjunction with this report, three-fourths of the respondents interviewed have Blue Cross-Blue Shield coverage. The auditor's analysis of paid claims indicates that Blue Cross-Blue Shield coverage was held by 33% (17 of 52) of the selected claimants. Blue Cross-Blue Shield has informed us that all of their major medical contracts now contain a coordination provision, either in the policy or attached by rider. By the terms of this provision, American Family's policies are subject to coordination.[2] The insured is obligated to inform Blue Cross-Blue Shield of the existence of other policy benefits, and Blue Cross-Blue Shield has a cause of action to recover any overpayments made. The reduction is computed so that the total of the other policy's payments, taken together with Blue Cross-Blue Shield reimbursement, shall not exceed the "allowable benefit" which is defined as "any necessary, reasonable and customary item of service or care [which is] covered in whole or in part..."

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[2] Blue Cross-Blue Shield Master Medical Certificate MM-1, Revised 2-1-68 (3rd printing 1-1-77).

It is clear that coordination of benefits is a very real problem for American Family policyholders. The provisions of the Blue Cross-Blue Shield contract will cause coordination. Blue Cross-Blue Shield coordinates against other policies on the basis of "item(s) of service or care." It is argued that the A-8011, Hospitalisation Indemnity Plan, will not be coordinated against because it does not refer to specific items of service or care. However, the provisions of Blue Cross-Blue Shield's contract admitts to no such restrictions. They might, if challenged, argue that the hospital's total bill represents a charge for an item of service or care. To the extent that Blue Cross-Blue Shield coverage exceeds the total bill, coordination could apply. Because this provision can cost the policyholder a loss of benefits, failure to inform the insured of the existence of coordination of benefits constitutes a violation of chapter 93A, §2 and the Attorney General's Consumer Protection Act Regulations, section XVB.

c. LOSS RATIOS

An analysis of loss ratios (ration of paid claims to earned premium) for Massachusetts insured by policy type yields a ratio of 42% for all types of insurance and a ratio of 43% for cancer-only policies. An analysis by policy issue year reveals that as the policies get older, the loss ratio becomes much higher, and in some cases even exceeds 100%. Massachusetts' experience over the subject period of 1/1/77 through 6/30/78 is too short and contains too few policies to adequately analyse the losses to be expected. The Company has also calculated projected loss ratios for its own purposes for a policy with "standard benefits" and an assumed 45 day waiting period. That table shows expected loss ratios of 26.6% in the first year and 66.0% in the tenth year after issuance, taking into account losses and mortality of insureds. It is indicated that this shows that at some future date rate increases will be required if the trends in average claims continues. As it has encountered unfavorable loss experience the Company has increased the premium on cancer policies sold in other states, and is contemplating the same in Massachusetts. The policies provide that an increase may be made, statewide by policy type, in an

pages tightly bound

apparent violation of Regulation 2-74, section 32, which prohibits increases in the price of specified disease policies.

d. COMMISSION STRUCTURE

The Company's commissions constitute a high percentage of first year premiums collected, and a uniform 10% of all renewal premiums. First year commissions on cancer policies range from a high of 50% to a low of 13%, depending upon the policy type and the billing mode. Commissions are generally lower for more frequent (e.g. quarterly, monthly) billing modes and for policies which are sold to payroll and association groups rather than to individuals.

B. AGENT'S LICENSING AND TRAINING

1. AGENT'S LICENSING

The Agent's Licensing Department files on Massachusetts' Agents were examined. Ideally, the department keeps a folder for each active Massachusetts agent, complete with the following items:

(1) A personal history information sheet completed by the agent when applying for a job with the Company,
(2) An Equifax or other retail credit report on the applicant,
(3) The agent's contract with the Company;
(4) All documents regarding licensing;
(5) Certifications as to the training of new agents;
(6) All matters regarding termination and reinstatement of agents.

The files were examined for exceptions, completeness, and unusual items. The files examined were largely incomplete. "Personal history information" sheets are incomplete in many of the files. Some forms are blank, beyond the information needed to identify a person as to name and address, and in some files there is no personal history sheet. Agents are canceled for nonproduction and then reinstated with no evidence on file that any examination of the agent's current status or what the agent has done in the meanwhile. Possibly one-half of all the files contain no information regarding an independent or credit checkup on the agent via Equifax or Consumer Credit or otherwise. The qualifications of the new agents, as shown by the files, are such that they would indicate that there are no minimum standars for hiring. The files show nine instances in which the Company's agents applied to the Commonwealth of Massachusetts for a license to sell the Company's insurance before their application to the Company was approved. Training certificates are not to be found in the majority of the files. The files of canceled agents were less complete than those of active agents. An examination of every third file revealed that only one of the 13 files examined indicated that the agent had any prior experience. No independent investigative report was filed in 11 of the 13 files examined.

Terminated agent's files largely consist of those who have never before sold insurance. A lack of reporting on the background is evidenced and there is nothing in the files that would indicate that applicants are rejected by the Company for any reason.

It is worthy of note that there have been some recent changes in procedures. The practice in effect with regard to Massachusetts agents is to now do in-house investigations only as permitted by ch. 175, § 175. The Company is now requiring that the personal histories be fully completed. The personal history information is then verified by Agent's Licensing personnel by telephone or letter. A letter is sent to all personal references who cannot be contacted by telephone. On the personal history information form itself, the Manager certifies as to the agent's identity, residence, experience, and that the agent is trustworthy, etc. There have been no new agents in Massachusetts since the inception of these procedures. However, it does appear that the above-stated policies are in effect uniformly for all states.

These conditions indicate that the Company has in the past not adequately investigated the background of new agents in Massachusetts, nor has it required adequate proof of proper training. The practices followed by the Agency Licensing Department indicate that all matters such as the screening of applicants, the training of those applicants for licensing exams and the activities of agents are left to the state and district managers to deal with as they see fit.

Based upon the foregoing, the following recommendations are made:

(1) That the company conduct interviews with managers to see exactly what they are doing with respect to recruiting, training and licensing of new agents.

(2) That the Company establish specific requirements for the conduct of recruiting and licensing of new agents.

(3) That the company continue to apply its recently adopted procedures for review of new applications.

(4) That when an applicant has an unsatisfactory or blemished record, sufficient notation should be kept in the agent's file to indicate that an informed decision was made with

knowledge of such facts, stating on what basis that decision was made.

(5) That the agent's files be kept complete, including but not limited to, the:
  - (a) Personal history,
  - (b) Training,
  - (c) Record,
  - (d) Complaints,
  - (e) Licensing Applications,
  - (f) Licenses Issued, and
  - (g) Updated personal history and review of reinstated agents.

2. TRAINING

a. FOR STATE EXAM

Twenty hours training is required by law for new accident and health insurance applicants. The California State exam training courses are presently used to train Massachusetts agents, as it is found to be a more applicable test preparation text for the test Massachusetts is using currently than the training course that was created in-house. The courses are taught by the State or District Manager in motel rooms or at home, and there is allegedly no self-study. No records of attendance or grading have been kept. The cost of other training schools approved by the Commissioner of Insurance is considered prohibitive at $75 per student per course.

b. SALES TRAINING

The training carried out by the Agents Training Department is geared towards recruitment of personnel, motivation of personnel, and sales. It is not directed towards compliance training for meeting state licensing requirements. The primary documents used by the Company in its training program are the Training Handbook and the State and Regional Training Manual. The program is geared toward training the agent to sell the product. No emphasis is placed upon training the agent about insurance. The sales program is designed to allow the agent to make a

best copy available

presentation while thwarting any attempt on the part of the customer to protest or ask meaningful questions. The presentation itself is basically the same information as is contained on the sales brochures.

The agent is instructed how to be forceful and evasive so that he can get into the house of an unwilling prospect without letting the prospect know what he is selling. The agent is instructed, when faced with the inital question, "is it insurance?" to "take charge at this point--BE STRONG! BE POSITIVE!" and reply "WHAT I HAVE TO TELL...I ALSO NEED TO SHOW YOU... IT WILL ONLY TAKE A FEW MINUTES...MAY I COME IN?" If the prospect indicates that he or she has sufficient insurance, the agent is to explain"...we don't have any insurance. The doctor who treats you has insurance his bills will be paid. The hospital has insurance its bills will be paid. But, in reality. you do not have any insurance." The agent is instructed to state that the policy only costs 21¢ per day, to combat the protest that the buyer doesn't have any money. Finally, the salesman is instructed to utilize the statistics from the [cancer will] strike sheet as "additional ammunition" whenever needed.

The Massachusetts Attorney General has promulgated regulations pursuant to M.G.L. 93A, dated July 1, 1971. Section VIII of those regulations, entitled Door to Door Sales and Home Improvement Transactions, states:

> "In connection with any door to door sale, it constitutes an unfair or deceptive act or practice for any seller to:
>
> A. At the time of initial contact, and before making any misrepresentations, or fail to state any material fact which has the capacity or tendency to disguise, hide or fail to inform the purchaser of the purpose of the contract;
>
> B. Make any representation, in the sale, offering for sale, advertising, or distributing for sale, or in any other manner, including the failure to adequately disclose additional relevant information, which has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers with respect to any material aspect of the product or transaction;
>
> C. Fail to disclose the exact nature, description and price of the goods or services which are to be the subject of the transaction to the purchaser or prospective purchaser in advance of any attempt to induce

the purchaser or prospective purchaser to enter into
1. an agreement in writing, or
2. to pay any consideration to the seller.

Section XV of the same regulations states that an act or practice is a violation of Chapter 93A, section 2, if:

A. It is oppressive or otherwise unconscionable." in any respect; or
B. Any person or other legal entity subject to this act fails to disclose to a buyer or prospective buyer any fact, the disclosure of which may have influenced the buyeror prospective buyer not to enter into the transaction.

Being evasive at the door as to the nature of the prodcut being sold is an apparent violation of section VIII, A and B of the Attorney General's Rules and Regulations (hereinafter, "Regulations"). High pressure techniques are an apparent violation of Regulations, §XV A, as "oppressive or otherwise unconscionable in any respect..." Making a statement to the effect that "we don't really have any insurance" has the capacity to mislead the buyer, in apparent violation of Chapter 93A and Regulations, § VIII A and B. The use of 21¢ per day as a price for the insurance tends to mislead and constitutes an apparent violation of Regulations §VIII. When the agent is informed that the prospect has other insurance, the agent should then be put on notice that there may be problems with coordination of benefits, overlapping coverage or over-insurance. To teach agents to purposely fail to meet the issue in any meaningful way constitutes an apparent violation of Regulations section XV, B.

c. CONCLUSIONS AND RECOMMENDATIONS AS TO TRAINING

Training for the state licensing exam is carried on in the field without any supervision or review by the company. No records are kept of attendance or performance. Training for the exam is entirely separate from the sales training program. The Company's sales training program is unacceptable because of the violations of Consumer Protection Regulations which exist, as described above. When sales training is taught entirely in the field, as is usually the case in Massachusetts the Company has no reveiw over or supervision of the program. What is done or what is not done with either type of training in the field

occurs without any input from Company officials. That is the fundamental problem to be corrected. It is recommended that there be salaried personnel at the state level to see that training for licensing and sales training is carried out properly. The overall emphasis of the program must shift from high pressure, low information sales to a sales presentation of an educational, informative and relevant nature.

C. SALES PRACTICES

The Massachusetts state sales organization works independently from the national office. This results in sales approaches which bear little relationship to the Company's training program. The Company's sales, training, licensing and compliance departments purport to standardize the overall practices and methods of the organization. At the same time, the State and District Manager's loosely connected structure and compensation program allows the managers to establish whatever practices and methods they see fit. The natural inclination is to emphasize sales at the expense of all other considerations, while the Company finds it difficult to play the spoiler when it, too, benefits from increased sales.

1. SALES MATERIALS USED

The Company supplies folders of company-approved sales materials for use by agents. This folder is distributed to agents at the introductory sales training course. The materials actually distributed to agents who do not attend the course will vary, depending upon what materials are supplied by the State or District Managers. These are further modified by the agents themselves, who may develop their own selling material to fit their needs. After the initial contact with the new agent, the Company has no procedure for regulating the agents' use of promotional materials.

We were able to examine one Massachusetts agent's materials. Some items of exceptional interest were found in that sales package. Letters regarding coordination of benefits are used as part of the sales materials. The letters were addressed to American Family Life Assurance Company, from insurers in other states, indicating that those companies would not coordinate against the American Family cancer policy. The letters were from companies in states where the insurance laws prohibit coordination of benefits, unlike Massachusetts. Included in the materials was a copy of an approved claim in the amount of $54,091.70, paid to the holder of a double-benefit policy unlike the policy being sold. The agent indicated that although he uses this in his presentation, he does not explain the double policy distribution to buyers because it confuses them or because they then want to purchase the double policy.

Both the agent and an official within the Company confirmed that the use of materials developed by the agents is a practice of which the Company has knowledge. The agent's contract gives the Company the right to restrict the materials used by agents, but apparently this right is rarely used.

2. DOOR TO DOOR SALES

In Massachusetts, door to door sales are rarely done "cold." Generally there is a list provided for or generated by the agent which he uses to determine where to call. The lists that are most commonly used in Massachusetts are those of members of the Massachusetts State Grange and voter registration lists. The voter lists are used to find residents who are over 60 years of age.

One agent demonstrated his sales presentation, using the above described materials. In most respects, his sales talk followed the format used in the Company's brochure. However, the $54,091.70 double policy claim was exhibited, and the out of state insurance company letters were used to explain that coordination of benefits wouldn't apply.

3. CLUSTER SALES

The growth of the Company is largely due to the development of the cluster selling technique, which is the selling of individual policies to members of a group. In the usual case, salesmen obtain permission from an employer to sell to the employees. Although the employer is not specifically asked to endorse the product, the employers may imply such endorsement when the salesman is given permission to speak to the employees.

One agent's experience is that once the presentation is made, it is not uncommon for 50% to 100% of the individuals in the group to buy the cancer policy. Apparently, the technique fails when one person in the group heckles the salesman. When that happens, it is very likely that no one will buy, regardless of the substance of the heckler's statements. Interviews of people who purchased the policy at work indicate that peer pressure is a strong impetus in the buyer's decision. People do things in groups. Peer pressure is very strong. The unity of group thought and the endorsement of the employer compels the doubtful individuals in the crowd to go along, except in that situation where one person chooses to defy the salesman. The doubting members then form another group, towards which the rest of the members may gravitate.

The logic of this analysis is further borne out by the fact that if one individual in the group has a good experience (i.e., a quickly paid cliam), the remainder of the employees are likely to buy. Conversely, when one employee has a bad experience with his insurance, all of the members of the plan are quick to cancel.

4. DIRECT MAIL SALES

Although the Company claims not to have a direct mail sales program, three instances of direct mail sales were noted.

a. Among the advertising materials supplied to the examination tema by the Company is a letter that was drafted to solicit direct mail sales of cancer policies in Massachusetts. It is not known whether this letter was in fact ever used.

b. The agent in the District of Columbia sold Pennsylvania FIC-2A and FIC-2 policies to Massachusetts postal workers under the endorsement of the Post Office Association. All of these policy issuances took place in 1970 and 1971. The actions of the agency selling the Post Office Association policies places the agency within the definition of "Agent" as defined in ch. 175, §162. The agency is not licensed to sell the Company's policies in Massachusetts, which constitutes an apparent violation of ch. 175, §162, with penalties provided for in ch. 175, §166.

c. The Brandeis policy is sold nationwide, through direct mail, by a Massachusetts Agent located in Texas. These are currently being sold in this manner. The premise upon which the Brandeis policy is sold is that it has received approval in Massachusetts. The premise is faulty because the policy, as issued, does not qualify as group insurance. The company has represented to other states that they cannot be stopped from issuing certificates under this policy in those other states, because the master policy has been approved in Massachusetts.

5. CONCLUSIONS AND RECOMMENDATIONS AS TO SALES PRACTICES

The failure of the Company to keep a file of all marketing materials produced independently by its agents is an apparent violation of Regulation 1-74, §17, which requires the maintenance of an advertising file.

The use of the out of state letters regarding coordination of benefits and the inapplicable $54,000 + claim letter is misleading and therefore constitutes an apparent violation of ch. 93A, §2.

Apparent violations of ch. 175, §§108 and 110 were committed in the course of marketing the Brandeis policies.

The Post Office Association members were apparently sold policies that were not approved, in violation of ch. 175, §108 by an unlicensed agent, in violation of ch. 175, §162.

The Company apparently exercises little or no control over its agents' practices. By law it is responsible for the acts of its agents, and by the terms of the contracts it retains the right to control the agents' activities.

It is recommended that the Company tighten its system to eliminate the fundamental conflict that exists between sales and compliance. Specifically, agents should be recalled in order that the Company may find out what materials are being used. The salesmen must be educated to use sales techniques that are in compliance with the law. A Company line must be established on such subjects as coordination of benefits, and the agents must follow that line. If the disclosure of coordination of benefits is fatal to the Company's policy, the policy should be re-designed so that it really does fill the gaps left by other major medical policies. If it does in fact fill the gaps left by another policy, as it is advertised to do, then coordination will be of no effect. The point is that problmes cannot simply be ignored. The Company must also supervise all direct mail by requiring prior approval of all programs started and changes made. Finally, some sort of compliance testing would be advisable to ensure that agents are performing as they should. Company officials might make trips to cluster sales presentations, or interview persons who were sold policies in their homes, to ascertain that unfair and deceptive practices have been stopped.

D. COMPLAINTS, POLICYHOLDERS SERVICES

The following points are noted with respect to the Policyholder's Services Department:

1. No record of telephone inquiries is kept.
2. The Department does not retain written complaints in a system that would enable retrieval of those complaints.
3. The State and District Managers and Agents do not keep records of complaints received by them.
4. Claim-related complaints are routed directly to the claims department, with no further follow-up by policyholders services.

Mass. Gen. Laws, ch. 176D, §3(10) requires the Company and its agents to keep a complete record of all the wirtten complaints which it has received since the date of its last examination which shall indicate the total number of complaints, their classification by lines of insurance, and the nature, disposition, and time of processing of each complaint.

Accordingly, the system does not comply with the provisions of ch. 176D, §3(1). The system maintained by the Company is satisfactory for its own purposes, but additional procedures are recommended to comply with the statute. Complaints received in connection with claims should also be integrated into the record-keeping of the Policyholder's Services Department. That department should remain aware of and keep records with regard to all complaints that are routed to Claims.

E. CLAIMS

The Company attempts to handle claims in as short a period of time as possible. This policy is seen as supportive of sales, where many of the policyholders in payroll deduction groups are in close contact with each other. There is no litigation currently pending between the Company and Massachusetts insureds regarding claims.

Unacceptable rates of error were uncovered in two areas of claims settlement procedures;

1. Benefits were not determined in agreement with the policy terms in 16.8% of the sample observed.
2. The explanation of benefits letter was incomplete as to additional benefits that were available upon submission of additional documents in 8.2% of the sample.

The reason for these results may be explained by:

1. The high turnover rate of employees in the claims department; or
2. The lack of adequate review for approval by experienced group instructors.

A more acceptable rate of satisfactory claims payment procedures could be attained through either the implementation of an in-house sampling plan or automation of the benefit adjudication process.

The practices employed by the Company tend to cause an undesirable level of errors of omission, which appear to constitute unfair methods of competition, as defined in Chapter 176D of the General Laws. Specifically, ch. 176D, §3(1)(a) prohibits the misrepresentation of the benefits of any insurance policy. Unfair Claim Settlement Practices as defined in §3(9) of that chapter include the following acts or omissions:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; and

(b) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

The findings outlined above indicate that steps need to be taken to insure that benefits are determined more accurately than in the past, and that the explanation of benefits letters do not understate the benefits allowable by the policy terms.

Market Conduct Examination Report
# of the
American Income Life Insurance Company
1978

Division of Insurance
Commonwealth of Massachusetts

The Commonwealth of Massachusetts
Division of Insurance
100 Cambridge Street, Boston 02202

NAIC Market Conduct Examination
Subcommittee
The Honorable Richard L. Block
Director of Insurance
State Office Building
Juneau, Alaska 99811

The Honorable H. Pete Hudson
Insurance Commissioner
509 State Office Bldg.
Indianapolis, Indiana 46204

The Honorable Stephen F. Clifford
Commissioner of Insurance
100 Cambridge Street
Boston, Massachusetts 02202

Dear Commissioners:

At the request of the Commonwealth we have conducted a limited market conduct examination of American Income Life Insurance Company ("Company") of Indianapolis, Indiana as at December 31, 1977 and of certain items relating to subsequent periods.

The American Income Life Insurance Company is an Indiana domiciled insurance company with its administrative office located in Waco, Texas transacting accident and health and life insurance business in 48 states under a general agency system. The Company's admitted assets and premium income at and for the year ended December 31, 1977 is $78,315,477 and $51,699,166, respectively. The premium income for the year ended December 31, 1977 in Massachusetts amounted to $1,330,162.

The examination team was comprised of representatives from Coopers & Lybrand who addressed those areas which required accounting expertise and Mr. Paul Gitlin, Esquire, who addressed those areas which required legal expertise. The team coordinated their work and findings under the supervision of members of the staff of the Massachusetts Insurance Division. R L Associates, a marketing research firm, interviewed many policyholders as part of the examination and their report is attached.

Our examination was directed primarily to company issued Dread Disease Policies, which are marketed in the Commonwealth of Massachusetts. It was intended that we would also review Medicare Supplement types of coverage, but our inquiry disclosed that such coverage is not currently offered by the Company.

The scope of our examination was dictated by a Special Market Conduct Program ("SMC Program") and included requesting and receiving the following from the Company:

A. Listings of current Massachusetts agents and the company's files on terminated agents for the period January 1, 1977 to September 30, 1978.

B. Copies of cancer policy forms CAN (873) and CDK (1174) and all marketing material incident to their sale.

C. A copy of the application form utilized by the Company in the issuance of the cancer policy.

D. A statutory annual statement for the year ended December 31, 1977.

E. Copies of the reports from the Missouri Division of Insurance, dated January 1976 and September 1978, on the Market Conduct Examinations of the Company.

F. Copies of agent contract forms.

G. Organizational chart of the Company.

H. Listing of paid claims on cancer policies in Massachusetts and the corresponding premiums on all policies.

I. Information concerning the Company marketing system and philosophy.

J. Listing of Massachusetts cancer and medical supplement policies in-force at October 18, 1978.

K. Listing of Massachusetts cancer and medical supplement policies terminated during the period January 1, 1977 to October 17, 1978.

L. Summary of all Massachusetts applications for life and accident and health submitted, declined and issued.

M. Copies of complaint files for the period January 1, 1977 to September 30, 1978.

The incurred loss ratio on cancer polcies issued to Massachusetts policyholders was not readily determinable; however the premiums written to losses paid for the most recent thirty-three month period developed a ratio of 25.17%. It would appear that the paid loss ratio would approximate the incurred loss ratio over such a period. ✓

With respect to each of the above, we read the documents and formulated questions, and completed the appropriate sections of the SMC Program applicable to such items. Additionally for each item specifically described below, we have listed our findings which require your consideration.

Findings and Recommendations

A. Underwriting Procedures Should Be Changed

Cancer policy underwriting at the time of the application consists solely of reviewing whether the applicant has indicated "yes" or "no" relative to their cancer history. If the answer is "no", a policy is issued. If the answer is "yes" the application is denied. No exceptions are made due to age, occupation or other factors.

When a claim is received, if there is any evidence that the applicant had cancer prior to the application or within a certain number of days after the policy issue date, the claim is denied, if the evidence proves to be correct.

In some instances, this method of underwriting could purport coverage to a policyholder which will not exist at the time a claim is filed.

We recommend that the Company's underwriting procedures be modified to include a review of medical records prior to the approval of the application.

B. The Company's Complaint Follow-up System Needs Strengthening

A discussion with management indicated that the Company does not have any system to insure that policyholder complaints are resolved satisfactorily and on a timely basis. Complaints other than those sent to the State Insurance Departments are distributed directly to the appropriate departments are generally given to clerks for resolution, and are then filed in the respective policyholder's file.

We recommend that the Company establish central control over the complaint system. This could be accomplished by:

1. Establishing numerical control over complaints by entering them in a register as they are received. This register would reflect the date received, nature of complaint, and date of satisfactory resolution. Further, this register should be maintained by someone independent of the departments to which the complaint pertains.
2. Preparing periodically a report which would summarize the complaints by nature and average disposition time. Further, this report should be reviewed by a responsible official and appropriate follow-up action taken when and if the results are unacceptable.

C. Amendments to Policy Applications Resulting in Reduced Coverage Should Be Agreed to by the Policyholder

During our review of the policyholder complaints which were sent to the Massachusetts Insurance Division, we noted one example where a policyholder's coverage per the application was reduced prior to the policy issuance to correspond with the Company's stated premium amount, without the consent of the policyholder. Since one of the Company's sales methods is directed towards a stated premium amount rather than a stated policy amount, errors of this type can occur. Upon processing the application, the new business department unilaterally reduces coverage and attaches an endorsement to the policy reflecting the amended amount of coverage.

We recommend that changes of this nature should be authorized by the policyholder. This could be accomplished by a form which could be prepared by the company, signed by the policyholder, and retained in the policyholder's file.

D. Policy CAN and CDK Marketing Material

The company sells two cancer policies in Massachusetts; the CAN policy and the CDK policy. The CDK policy is marketed by direct contact by agents with union governing bodies. The CAN policy is marketed by agents using a prepared statement and associated visuals with individual consumers. The leads for this sales presentation are obtained by using a letter prepared by the company agents and mailed on union or credit union stationery.

The marketing materials used by this company appear to violate numerous Massachusetts statutes including Massachusetts General Laws (MGL):

C. 175,§110E

C. 176D, 3 and 11

C. 93A, §2(a), as follows:

1. The marketing materials do not contain information concerning the average financial cost of the treatment of cancer. Because of the extensive fear of getting this disease, many people tend to over estimate the total cost of treatment and to be unable to determine the extent to which these costs relate to medical care as compared to the associated non-medical costs. Without such data it is difficult to determine if the policy benefits available are worth the premiums charged.

   The failure to disclose the average financial cost of cancer appears to violate M.G.L.:

   c.176D, §11, Regulation 5A and 6A;

   c.175, §110E, Regulation (1-74) 5A and 6A;

   c.93A, §2(a), Regulation III, IV A, XV B and XV C.

   because this disclosure, if made, might influence a prospective buyer to seek alternative insurance coverage or might result in the decision that the present insurance coverage is adequate.

2. The marketing materials refer to an aggregate benefit obtainable under the CAN policy. This amount is overstated by ten percent, because the materials include reference to a policy provision which provides a ten percent additional benefit which has not been approved in Massachusetts.

   The misrepresentation of the benefits offered by the policy appears to violate M.G.L.:

   c.176D, §11 Regulation 5B and 6A(1),

   c.175, §110E Regulation (1-74) 5B, 6A(1), 9A; and 10A;

   c.93A, §2(a), Regulation IA, IV A and XV C.

   All references to an automatic ten percent increase in benefits should be stricken from the marketing material and the premium schedule should be reviewed to determine whether a ten percent reduction is in order.

3. The policy is marketed by emphasizing the aggregate benefits available. This sum is used as a focal point for the visual part of the presentation and is repeatedly referenced in the verbal part of the presentation.

   While the agent making the presentation is told to say that this aggregate sum will not be paid in every case, he/she does not inform the potential policyholder of the substantial improbability that claims will approach this amount. The policy provides an aggregate benefit of $32,400.00. The average policy claim for the period January 1, 1977 through June 30, 1978 was $1,396.15. Accordingly, to receive the full aggregate benefit, the average policyholder would require twenty-three distinctive claim opportunities.

   The marketing method emphasizing an aggregate benefit which is unlikely to be paid by the company has the capacity of deceiving consumers concerning the potential benefits of obtaining this policy, and therefore, appears to violate M.G.L.:

   c.176D, §11, Regulation 5A, 5B and 6A(1);

   c.175, §110E, Regulation (1-74) 5A, 5B and 6A(1);

   c.93A, §2(a), Regulation III, IV A, and XV C.

   The marketing materials should be changed so that they do not emphasize the aggregate benefits but instead emphasize the benefits provided for each covered procedure or event.

4. The agent is instructed to read a letter at the beginning of the presentation which states that one of the two most crippling expenses a family can incur is cancer (the other being death). Massachusetts data indicates that the most prevalent and most costly disease afflicting this state's population is not cancer but rather, heart disease.

   The misrepresentation of the relative expense of cancer appears to violate M.G.L.:

   c.176D, §11 Regulation 5A and 5B;

   c.175, §110E Regulation (1-74) 6A and 5B;

   c.93A, §2(a), Regulation IV A and XV C.

5. The verbal presentation contains a reference to the usual cost of cancer treatment in the range of $30,000. to $40,000. Available statistics indicate the total cost of cancer is below $20,000. Much of this cost is not treatment related, but rather includes the costs associated with child care, and other factors. This clarifying information is not disclosed, nor is the fact that the policy offered is not designed to indemnify a consumer for these subsidiary costs.

   The use of information which is not sufficiently clear and complete to avoid confusion, and the failure to disclose additional relevant information appears to violate M.G.L.:

   c.176D, §11 Regulation 5A, 6A(1) and 6A(11);

   c.175, §110E Regulation (1-74) 5A, and 6A(1);

   c.93A, §2(a), Regulation IV A, XV B and XV C.

   The source of this statistic is not identified and this failure appears to violate M.G.L.:

   c.176D, §11 Regulation 10C;

   c.175, §110E Regulation (1-74) 9C;

   c.93A, §2(a), Regulation XV C.

6. The prospect is told that a decision must be made at the completion of the presentation because the agent cannot come back into the home. The examination team observed at a company sales meeting that agents were instructed to make repeat calls when necessary.

The misrepresentation of the agent's availability for repeat visits and the effect of this statement appear to violate M.G.L.:

c.176D, §11 Regulation 5B;

c.175, §110E Regulation (1-74) 5B;

c.93A, §2(a), Regulation IV A and XV C.

7. The marketing method is designed to create or enhance the consumer's fear of contracting cancer. The visuals include a page of names, printed on a black background, of famous individuals who have died of cancer, and a corresponding page on which the following words appear: "CANCER CAN HAPPEN TO YOU." The associated verbal presentation recites statistics concerning the number of Americans who have or will get cancer.

The inclusion of this otherwise superfluous information creates or enhances an emotional atmosphere of concern about contracting cancer. Insurance purchases should be contemplated and made for functional reasons, and not as a result of an artifically created fear of being afflicted with a particular malady. The infusion of this information has the effect of concentrating the consumer's attention on the disease itself, and away from the costs and possible benefits of the policy. This may trigger purely emotional responses to the purchaser's innate fear of cancer, and may result in a decision to purchase based on irrational reasons.

Inducing the purchase of insurance for emotional rather than functional reasons appears to violate M.G.L.:

c.176D, §11, Regulation 6A(11);

c.93A, §2, (a), Regulation IV A and XV C.

8. The marketing methods used misrepresent the effect of other insurance policies on the consumer's retention of benefits provided by stressing that the cancer coverage will pay expense benefits regardless of the existence of other insurance. While that representation is technically true, it is nevertheless misleading because it fails to inform the consumer that there exists a possibility in Massachusetts that the benefits provided by this policy will reduce any benefits expected from the consumer's other insurance policies, such as, Blue Cross and Blue Shield.

   The misrepresentation of the possible effect of overlapping insurance coverage appears to violate M.G.L.:

   c.176D, §11, Regulation 5A;

   c.175, §110E, Regulation (1-74) 5A;

   §93A, §(2)(a), Regulation III, IV A, XV B and XV C.

   because it has the tendency to mislead the public about the extent of insurance proceeds that may be paid.

   The effect of other insurance companies' coordination of benefit provisions should be clearly disclosed.

9. The agent is instructed to inform the prospect that payment will be made on a claim for cancer that is diagnosed by a physician any time after a one hundred and twenty (120) day waiting period. This is claimed to be true "even if the doctor says that that tumor has been growing there for 4-5 years". Since the policy's pre-existing condition clause requires a positive pathological determination of cancer, this statement appears to be correct. But the policy also contains a limit on payments for undiagnosed conditions to those medical costs incurred within ten (10) days preceeding the date of diagnosis. This limitation is not disclosed in the marketing materials. Therefore, the above quoted statement may deceive a consumer as to the benefits obtainable.

The non-disclosure and resulting misrepresentation appear to violate M.G.L.:

c.176D, §11 Regulations 5B 6A(1) and 6B(1);

c.175, §110E Regulation (1-74) 5B, 6A(1) and 6B(1);

c.93A, §s(2)(a), Regulation IV A, XV B and XV C

10. The marketing materials fail to disclose the extent to which the policy meets the costs of a short, average and long hospital stay as defined in the "Massachusetts Division of Insurance Hospital Cost Standards."

The company's failure to provide the required information appears to violate M.G.L.:

c.176D, §11 Regulation 6(3);

c.93A, §2(a), Regulation XV C.

11. The policy is guaranteed renewable, but the company has reserved the right to increase the premiums uniformly on all policies in force in Massachusetts. The fact that premiums may be adjusted at the company's option without specific Division approval is not conspicuously disclosed in any of the marketing materials.

The failure to conspicuously disclose the potential for premium increases without Division approval appears to violate M.G.L.:

c.176D, §11 Regulation 8;

c.175, §110B Regulation (1-74) 7;

c.93A, §2(a), Regulation IV A, XV B and XV C.

12. The visual portion of the presentation contains a statement in bold face that (the policy) "pays for pre-existing cancer after 120 days." This statement is followed in smaller print by the explanatory phrase that this is true provided that cancer has not been diagnosed prior to the expiration of this time period. This printing layout emphasizes the first statement and de-emphasizes the second with the possible effect that the consumer will misconstrue the pre-existing condition exclusion.

The practice of emphasizing, in positive terms, half of the company's pre-existing exclusion appears to violate M.G.L.:

c.176D, §11 Regulation 5A, 5B, 6A(1) and 6C(1);

c.175, §110E Regulation (1-74) 5A, 5B, 6A(1) and 6C(1);

c.93A §2(a), Regulation IV A and XV C

E. Policy CAN and CDV Application Form

The company uses an application form which requires that a consumer respond to certain questions and affix his/her signature. While the agents are actually directed to fill in the information obtained, the form is drafted as though the consumer is responsible for filling it in. For example, the first sentence consists of a statement that the consumer is applying for insurance and understands that the policy issuance will be based on the information provided. The sentence immediately preceeding the consumer's signature consists of a representation that the information is true and complete. It appears therefore, that the application should be treated for the purposes of this review as one designed and intended to be completed by the applicant.

The company's application form excludes certain required information and accordingly violates M.G.L.:

c.176D, §11;

c.175, § 110E;

c.93A, §2(a)

1. Although the benefits recoverable represent less than 50% of the cost of an average hospital stay, the application does not contain the required statement that "this policy is supplemental in its coverage and is meant to be purchased in addition to basic health insurance. This policy pays for __________% of the cost of an average stay in a Massachusetts Hospital as defined by the Massachusetts Division of Insurance Hospital Cost Standards."

   The company's failure to include the required percentage reimbursement information on the application appears to violate M.G.L.:

   c.176D, §11, Regulation 6A(3) and 7A;

   c.93A, §2(a), Regulation IV A, XV B and XV C.

2. The application fails to clearly and unambiguously disclose the company's pre-existing condition exclusion provision. The only semblance of a disclosure concerning the pre-existing condition exclusion is found in a question asked on the application. This question concerns whether any person to be covered under the policy has or has ever had or been told he had cancer. While this procedure introduces the concept of the exclusion, it is neither a clear nor a complete statement of the company's exclusion policy.

   The failure to include a clear and unambiguous statement of the Company's pre-existing condition exclusion in the application appears to violate M.G.L.:

   c.176D, § 11, Regulation 7B;

   c.93A, §2(a), Regulation IV A and XV C.

3. The application fails to contain most of the additional information required by Massachusetts Insurance Division regulations. In addition to its failure to include the information described above in this report, the company fails to disclose: the existence and extent of the waiting period; the fact that the reception of some benefits are contingent on hospitalization; and the terms of renewability and premium guarantee. There is also no room provided on the application for the applicant's signature specifically indicating that he/she understands the required disclosures.

The failure to disclose this information appears to violate M.G.L.:

c.176D, §11, Regulation 7C, 7D, 7F and 7G;

c.93A, §2, Regulation XV B and XV C.

4. The application provided does not contain questions that elicit whether the insurance sought by the company replaces other accident and sickness insurance. Massachusetts Insurance Division regulations require that a specific disclosure must be made if a consumer is replacing present coverage by purchasing a new policy. To effectuate this disclosure, the regulation also requires that any application ask questions designed to elicit this information.

   The failure to include questions designed to elicit this information appears to violate M.G.L.:

   c.175, §110E, Regulation (2-74) 23(1);

   c.93A, §2(a), Regulation XV C.

F. CDK Policy Form

The company filed this policy with the Division on December 19, 1974; it was approved on December 26, 1974. The following problems were found to exist in this policy form.

1. Certain of the benefits provided in the policy are based on the "usual and customary" fees charged by providers of the covered services. The policy form does not contain an explanation of this term in the form reviewed.

   The failure to adequately define the term "usual and customary" appears to violate M.G.L.:

   c.175, §110E, Regulation (2-74) 5(14);

   c.93A, §(a), Regulation IV A, XV B and XV C.

2. The room and board benefits provided by the policy do not equal the average Massachusetts semi-private room accommodations for at least sixty (60) continuous days of hospital confinement.

   This failure to provide benefits equal to the average cost of a semi-private hospital room appears to violate M.G.L.:

   c.175, §110E, Regulation (2-74) 5(31);

3. The company has reserved the right to increase premiums on all policies within the state.

   The reservation of the right to increase premiums of a specified disease policy appears to violate M.G.L.:

   c.175, §110E, Regulation (2-74) 5(32);

   c.93A, §2(a), Regulation XV C.

G. CAN Policy Form

The Company filed this policy on October 4, 1973. The Division approved this policy on October 23, 1973.
M.G.L. c175, §110E, Regulation (2-74) 25 states that these regulations shall apply to policies filed with the Division on or after December 1, 1974. It therefore appears that this policy is presently exempt from these regulations.

The following list of regulations should be reviewed if this policy is refiled with the Division,

M.G.L. c/75, §110E, Regulation 2-74), 5(19),
5(31 a and b), 5(32), 14 and 23.

General Comment:

The violations pointed out in this report must be corrected and the recommendations implemented. The Company will submit to the Division of Insurance within sixty days of publication date of this examination report, a report stating how these violations have been corrected and recommendations implemented. New cancer expense policy and application forms and related promotional material must also be submitted within sixty days. The Legal Section of the Division of Insurance will consider the institution of disciplinary proceedings where appropriate.

* * * * * * * * * *

very truly yours,

Alan J Wright
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Chief Examiner

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POLICYHOLDERS OF

AMERICAN INCOME INSURANCE COMPANY

A Study
Conducted for

THE MASSACHUSETTS DIVISION OF INSURANCE

INTRODUCTION

The Massachusetts Division of Insurance, as part of its audit of American Income Insurance Company, decided to incorporate actual testimony from policyholders. The Division at this time is particularly concerned with the sales practices of companies who sell the so-called "dread" disease or cancer coverage policies. The Division believed that the testimony of actual policyholders would provide greater depth to its understanding of the actual knowledge, behavior, and understanding of consumers and the role that the insurance companies themselves play in the education of consumers.

The material covered in the questionnaire and the sample design were structured to mesh as closely as possible with the known sales practices of American Income Insurance Company. This report presents findings only from the actual surveys conducted among policyholders.

Background

American Income Insurance Company presents itself as a union label company. Its primary selling approach is through unions. Almost all policies are sold by agents rather than through the mail.

Questionnaire

The questionnaire (see Appendix) was designed to obtain information in the following areas:

1) Other insurance coverage of the respondent, in particular Blue Cross/Blue Shield, Medicare, and other major medical policies. This knowledge was important primarily because of coordination of benefits clauses in the Blues.

2) Any experience with cancer policies by the respondent. This was to identify types of respondent.

3) Respondent purchasing mechanism (through an agent, through union recommendation, etc.).

4) If the policy was purchased through the employer, the respondent's understanding of the employer's role and particularly the degree of employer endorsement.

5) If the respondent had contact with an agent either at home or at work, the respondent's present and past experience with the agent.

6) Reasons for buying cancer policies in general and this policy in particular. This area included:

- o Knowledge of the actual coverage provided by the policy,
- o Expressed reasons for buying the policy.

7) Other experience with American Income, notably claims or other contact over policies.

8) Demographics and other background information about the respondent.

Sample Design

The sample was drawn by American Income personnel from its own records. It included 800 individuals in Massachusetts who had been issued a cancer care policy by American Income during the period January 1, 1978 to July 31, 1978.

Interviewing

Interviewing was carried out by professional interviewers within Massachusetts during the middle part of November, 1978. Most of the interviews were conducted during evening hours or on weekends in order to obtain a good cross section of respondents, many of whom were of working age. Interviews were conducted by telephone, and all interviewers had had previous experience with this type of interviewing. In addition, all interviewers were briefed on this particular questionnaire and sample.

During the course of the interviewing, ABC News carried a succession of items on problems with cancer policies. As a result, interviewing was discontinued so as not to bias the results by that unfavorable publicity.

SUMMARY OF FINDINGS

Medical Insurance

The overwhelming majority of respondents to this study have some form of broad scope medical insurance policy. Seventy-two percent are covered by Blue Cross, 24% have another hospital insurance plan, almost all the older respondents have Medicare coverage, and 35% claim another form of major medical. All together, only 5% of those interviewed report having no broad scope medical coverage.

No Coverage	5%
Blue Cross only	37
Other but not Blue Cross	23
Other and Blue Cross	35

About three fourths of the sample say they have a cancer-only coverage policy as well, and another four percent say they have a non-cancer American Income policy. Thus, about one fifth of the sample do not recall having an American Income policy either by type of policy or by company name.

Virtually no one (2%) claimed to know the meaning of the term "coordination of benefits." Further only about one out of 12 of those who say they have both Blue Cross and another health insurance policy know that Blue Cross will not pay the entire bill if they were to make a claim to both Blue Cross and another company for the same bill. It is thus clear that few respondents know that Blue Cross uses coordination of benefits, and most feel they can collect more than once for the same bill if they have Blue Cross plus other policies.

Sales of Policies

About 85% of those who recall owning a cancer policy bought it at home. More than 90% bought the policy through an agent. Over 90% neither knew the agent before they bought this policy nor have they ever seen the agent again.

Only one in five said the agent pressured them to buy the policy the same evening, but six out of seven actually did buy their policy at that time. Buying the same evening as the agent's visit was facilitated by the fact that the policyholder's family was generally also present, and the agents spent an average of more than half an hour selling the policy. In two out of three sales, the agent also used a brochure.

Thus, the apparent sales pattern is for the agent to get into the home, often through a union recommendation, spend a reasonable length of time, sell the policy, and then get out without ever coming back again.

Union Endorsement

About one fifth of the respondents first heard of the policy through their union. Many others heard through fellow employees or in similar ways. Presumably as a result, three out of four of those with an opinion think the policy is endorsed by their union. On the other hand, only one out of 11 think that American Income is a "union" label company.

The agents do not seem to abuse this implied union endorsement. Most respondents did not think the agent presented himself as a union representative, nor did they see the policy as a supplement to their union contract benefits.

Overall, the company trades on an implied endorsement by the potential policyholders' union, but this appears reasonable in light of the union's general cooperation in providing lists of names.

Factors Motivating Policy Purchasing Behavior

The respondents in this sample say they bought a cancer policy because of fear of the disease itself or of its cost and because of the widespread incidence of the disease. They chose an American Income policy because of the implied endorsement of their union or because it was the only one they looked at.

At least some of the information about incidence and cost had come from the agent. Three fourths of cancer policyholders said that the agent had mentioned that "1 out of 4 Americans will eventually get cancer." Of those who recalled what the agent had said about the cost of cancer, almost 80% said that the agent had mentioned a cost range of $30,000-$40,000.

Knowledge of Benefits

While respondents are very concerned about the incidence and cost of cancer, they are not knowledgeable about the potential benefits of the policy. For instance, only one in four "knew" that there was a 60 day waiting period before the policy becomes effective.

More important, most respondents did not know the amount of benefits typically paid by the policy. Respondents were asked what part of a $20,000 and of a $2,000 bill for cancer would be paid by their policy. In both cases, most people did not even think they knew, and of those that did "know," the great majority thought the policy paid the total amounts.

Similarly, almost no one knew what coordination of benefits meant, and as indicated above, most people did not understand the concept as it applies to Blue Cross policies.

Claims

There were a very small number of respondents who had made a claim against American Income, and these people indicated no dissatisfaction.

CONCLUSIONS

American Income sells cancer policies primarily to working aged people using an implied union endorsement. Policies are sold in homes through agents.

Policyholders are not particularly well informed as to the benefits of the policies, and in many cases have overlapping coverage of several kinds.

American Income's agents are clearly more interested in presenting the horrors and catastrophic costs, real or imagined, of cancer than they are in describing the likely real benefits of the policies they sell.

PASTE LABEL HERE

Hello, my name is ______________. The Massachusetts Division of Insurance, the state agency which regulates and supervises insurance companies operating in the state, has asked us to interview people about their health insurance. If you wish, you may call Alan Wright at the Division of Insurance Chief Examiner's office (617) 727-4395 to confirm our credentials.

1. Are you personally covered by your own or someone else's Blue Cross/Blue Shield insurance policy?	1 YES 2 NO—GO TO Q. 5 3 DON'T KNOW—GO TO Q. 5
IF "YES" ASK:	
2. Have you ever read your Blue Cross or Blue Shield policy or a description of its benefits?	1 YES 2 NO 3 DON'T KNOW
3. Do you have any health insurance with any other companies in addition to Blue Cross/Blue Shield?	1 YES 2 NO 3 DON'T KNOW
IF "YES" ASK:	
4. If you were to make a claim to both Blue Cross/Blue Shield and to this other insurance company for the same bill, as far as you know would Blue Cross/Blue Shield pay the bill, pay a reduced bill or not pay the bill at all?	1 PAY THE BILL 2 PAY A REDUCED BILL 3 NOT PAY AT ALL 4 DON'T KNOW
i. Are you personally covered by Federal Government medicare insurance?	1 YES 2 NO—GO TO Q. 6a 3 DON'T KNOW - Go to 6a
IF "YES", ASK:	
6. Have you ever read a description of your medicare insurance coverage?	1 YES 2 NO
4. Do you have any other major medical insurance or broad coverage health insurance policy?	1 YES 2 NO 3 DON'T KNOW
. Do you have any health insurance policies with the American Income Insurance Company?	1 YES 2 NO 3 DON'T KNOW
IF "NO" ASK:	
8. Have you ever had any health insurance policies with the American Income Insurance Company	1 YES 2 NO—GO TO Q. 10 3. DON'T KNOW -- Go to Q. 10
IF "YES" ASK:	
9. Was this policy cancelled by American Income Insurance Company, or did you drop the policy yourself?	1 YES CANCELLED 2 DROPPED IT MYSELF 3 DON'T KNOW--GO TO Q. 10

IF POLICY CANCELLED BY COMPANY, ASK:

9a. Why did the company cancel your policy?

IF POLICY DROPPED, ASK:

9b. Why did you drop this policy?

9c. When you dropped this policy did you replace it with another one like it?

1 YES
2 NO

K EVERYBODY

. Some insurance companies sell policies limited to covering expenses specifically resulting from cancer. Do you have or have you had a policy that only covers cancer expenses?

1 YES, HAVE CANCER POLICY
2 YES, HAVE HAD POLICY
3 NO, HAVE NOT HAD POLICY

a. Do you have any cancer insurance policy that is attached to a life insurance policy?

1 YES
2 NO
3 DON'T KNOW

IF "YES" HAS ANY SORT OF CANCER POLICY, OR HAS HAD A CANCER POLICY, ASK: ALL OTHERS TO Q. 61 P. 8

11. How many policies that cover only cancer and no other illness do you presently have?

______ POLICIES
2 NONE—GO TO Q61, P. 8

12. What is the name of the company of your most recent (or only) cancer policy? (INTERVIEWER: PROBE FOR THE COMPLETE NAME, WRITE THE COMPLETE NAME BELOW.)

____

13. Have you actually received a copy of your cancer insurance policy?

1 YES
2 NO
3 DON'T KNOW

TERVIEWER: READ TO RESPONDENT: "Now I am going to discuss with you is most recent (or your only) cancer policy? This includes any that are part a life insurance policy.

. Did you first hear about this cancer policy from an insurance agent or from some other source?

1 AGENT
2 OTHER SOURCE

IF "OTHER SOURCE," ASK:

15. From what other source did you hear about this cancer insurance policy?

1 BROCHURE
2 FRIENDS, RELATIVES
3 FELLOW EMPLOYEES
4 LABOR UNION
5 OTHER ________

. As far as you know, does your labor union actually endorse this cancer policy as a good insurance policy?

1 YES
2 NO
3 DON'T KNOW

. As far as you know, is the American Income Insurance Company a union label company?

1 YES
2 NO
3 DON'T KNOW

IF "YES" , ASK:

17a. What does a union label company mean to you?

8. Did you purchase your cancer policy when you were in your home, or when you were at your job?

1 IN HOME
2 . AT JOB
2 OTHER ____________

19. Did you buy your cancer insurance through an insurance agent or did you buy it through the mail?

1 THROUGH AGENT
2 THROUGH MAIL
3 OTHER

IF BOUGHT FROM AGENT ASK BELOW. ALL OTHERS GO TO Q. 36

20. Where did the agent who contacted you get your name?

21. Did you personally ever discuss this cancer policy with the agent who sold it to you?

1 YES
2 NO
3 DON'T KNOW

21a. Did the insurance agent who sold you your cancer policy say he was a labor union representative?

1 YES
2 NO
3 DON'T KNOW

22. Did the agent who sold you this cancer policy also sell you any other type of insurance at the same time you bought your cancer policy?

1 YES
2 NO

IF "YES" ASK:

23. How many other insurance policies did you buy at the same time you bought this cancer policy?

________ Policies
X NONE
Y DON'T KNOW

24. Had you ever dealt with this insurance agent before he sold you the cancer policy, or was he a new agent?

1 HAD DEALT WITH BEFORE
2 NEW AGENT
3 DON'T KNOW

IF "HAD DEALT WITH AGENT BEFORE," ASK:

25. For how many months or years have you known the agent who sold you your cancer

______ MONTHS

EVERYBODY WITH A CANCER POLICY

Thinking of your most recent cancer policy, did you buy it to replace a former cancer policy, in addition to another cancer policy, or is it a completely new cancer policy?	1 TO REPLACE FORMER POLICY 2 IN ADDITION TO 3 COMPLETELY NEW POLICY 4 OTHER ______

IF "REPLACED" OR "IN ADDITION TO," ASK:

37. How much influence did your agent have on your decision to replace a former policy or add another one—a great deal of influence, some influence, or very little influence?	1 A GREAT DEAL OF INFLUENCE 2 SOME INFLUENCE 3 VERY LITTLE INFLUENCE 4 DON'T KNOW
Thinking of your most recent cancer policy, have you ever seen or read a brochure describing the terms of this cancer policy?	1 YES 2 NO 3 DON'T KNOW
Have you ever seen or read a disclosure statement describing the terms of your cancer policy?	1 YES 2 NO 3 DON'T KNOW

IF "YES", HAVE SEEN DISCLOSURE STATEMENT, ASK:

40. How much of the disclosure statement have you read—all of it, about half of it, or less than half of it?	1 ALL OF IT 2 ABOUT HALF OF IT 3 LESS THAN HALF 4 NONE 5 DON'T KNOW

What are your most important reasons for buying a cancer insurance policy?

Thinking of your most recent (or only) cancer policy, what made you especially choose that one company's policy rather than some other company's policy?

I am going to read you a series of statements. For each statement, please tell me whether your cancer policy provides that benefit or not.

	YES	NO	DON'T KNOW
a) Your cancer policy pays benefits for care in nursing homes or rest homes—yes or no.	1	2	3
b) Your cancer policy pays doctors fees for visits and examinations only when you are actually in the hospital. Yes or no?	1	2	3
c) Your policy will pay for illness or poor health caused by the cancer treatment itself—yes or no.	1	2	3
d) Your cancer policy covers you only after a 60 day waiting period from the time you buy the policy—yes or no?	1	2	3
e) Your cancer policy will pay for drugs purchased for cancer treatment after you are out of the hospital—yes or no?	1	2	3
f) Chemotherapy treatments for cancer are covered in your cancer policy—yes or no?	1	2	3

What are the maximum cancer benefits per person you could receive under your cancer policy—under $10,000, between $10,000-$25,000, between $25,000-$50,000 or more than $50,000?

1 UNDER $10,000
2 $10,000-$25,000
3 $25,000 -$50,000
4 MORE THAN $50,000
5 DON'T KNOW

If you received a total hospital/doctor's bill for $20,000 from a cancer illness, about how much of this bill do you think your cancer insurance policy would pay for —all $20,000, between $10,000 and $20,000, or less then $10,000?

1 ALL $20,000
2 BETWEEN $10,000-$20,000
3 LESS THAN $10,000
4 DON'T KNOW

If you received a total hospital/doctor bill for $2,000 from a cancer illness, about how much of this bill do you think your cancer insurance policy would pay for you—all $2,000, between $1,000 and $2,000, or less than $1,000?

1 ALL $2,000
2 BETWEEN $1,000-$2,000
3 LESS THAN $1,000
4 DON'T KNOW

As far as you know, on your cancer policy, can you choose to receive disability payments for loss of time from work due to cancer instead of having the insurance company reimburse you for your medical bills?

1 YES
2 NO
3 DON'T KNOW

Do you see any advantage to you in receiving cancer insurance payments as disability payments rather than as reimbursement for actual medical bills incurred?

1 YES
2 NO
3 DON'T KNOW

Have you ever heard of the term "coordination of benefits"as it applies to your cancer insurance policy?

1 YES
2 NO
3 DON'T KNOW

Have you ever written the company about your cancer policy or cancer coverage?
1 YES
2 NO } GO TO Q. 53
3 DON'T KNOW }

IF "YES", ASK:

51. How satisfied were you with the response of the company--very satisfied, fairly satisfied, or not too satisfied?
1 VERY SATISFIED
2 FAIRLY SATISFIED
3 NOT TOO SATISFIED
4 COMPANY HAS NOT RESPOND
5 DON'T KNOW

52. Have you ever had to write more than once to get an answer from the company?
1 YES
2 NO
3 DON'T KNOW

Have you ever made a claim under a policy that covered only cancer expenses?
1 YES
2 NO
3 DON'T KNOW

Have you ever made a claim against American Income Insurance Company on your cancer policy?
1 YES
2 NO
3 DON'T KNOW

IF RESPONDENT HAS MADE A CLAIM IN Q. 53 or 54, ASK: ALL OTHERS GO TO Q. 61

55. Was the claim paid in full, paid partially, denied, or is the claim still in process?
1 PAID IN FULL
2 PAID PARTIALLY
3 DENIED
4 IN PROCESS
5 OTHER

56. How much was your total claim to the insurance company?
$__________
Y DON'T KNOW

57. How much money did the insurance company pay you?
$__________
Y DON'T KNOW

58. Was this payment more than you expected, was it less than expected, or was it about what you expected?
1 MORE THAN EXPECTED
2 LESS THAN EXPECTED
3 ABOUT WHAT EXPECTED
4 DON'T KNOW

59. Did you also receive money from any other insurance for the same illness?
1 YES
2 NO
3 DON'T KNOW

60. Was the claim you submitted greater than your actual bills, less than your actual bills, or the same as your actual bills?
1 GREATER THAN
2 LESS THAN
3 SAME AS
4 DON'T KNOW

Now a few questions for statistical purposes. . .

61. How old are you?

_______YEARS

62. What was the last grade you completed in school?

1 HIGH SCHOOL INCOMPLETE
2 HIGH SCHOOL COMPLETE
3 SOME COLLEGE
4 COLLEGE COMPLETE

63. What is your marital status?

1 MARRIED
2 SINGLE, NEVER MARRIED
3 DIVORCED
4 WIDOWED
5 SEPARATED

64. How many people over age 18 live in your household, including yourself?

1 ONE
2 TWO
3 THREE
4 FOUR

65. What is your ethnic background? PROBE: Are you descended from Irish immigrants, etc?

1 IRISH, ENGLISH, WELSH, SCOTS
2 ITALIAN
3 EASTERN EUROPEAN (POLISH, HUNGARIAN, CZECH)
4 JEWISH
5 GERMAN, AUSTRIAN

6 SCANDINAVIAN (DANISH, NORWEGIAN, FINN, SWEDE)
7 FRENCH
8 SPANISH SPEAKING (PUERTO RICAN, CUBAN, ETC.)
9 ORIENTAL
10 BLACK (AFRICAN)
11 OTHER ________________________________

66. How many full-time wage earners live in this household, including yourself?

1 NONE
2 TWO
3 THREE OR MORE

IF ANY FULL-TIME WAGE EARNER, ASK:

67. Are you covered by any group health insurance paid in full or in part by the employer?

1 YES
2 NO
3 DON'T KNOW

68. Are you covered by any union health and welfare plan?

1 YES
2 NO
3 DON'T KNOW

69. Have you ever bought any insurance sold through this employer, but not paid for by the employer?

1 YES
2 NO
3 DON'T KNOW

70. Is your total family income under $15,000 per year, between $15,000-$25,000 per year, or more than $25,000 per year?
1 UNDER $15,000
2 $15,000-$25,000
3 MORE THAN $25,000
4 REFUSED

71. SEX: 1 MALE 2 FEMALE

72. Has anyone in your immediate family or among your friends had any form of diagnosed cancer within the past five years?
1 YES
2 NO
3 DON'T KNOW

Thank you for this interview!

TIME INTERVIEW ENDED__________ LENGTH OF INTERVIEW__________

INTERVIEWER'S NAME____________________

INTERVIEWER EVALUATION:

The respondent:
1 SPOKE ENGLISH VERY WELL
2 SPOKE ENGLISH ADEQUATELY
3 SPOKE ENGLISH POORLY

The respondent:
1 SEEMED TO UNDERSTAND ALL QUESTIONS VERY WELL
2 SEEMED TO UNDERSTAND MOST QUESTIONS
3 SEEMED TO UNDERSTAND FEWER THAN HALF THE QUESTIONS
4 SEEMED TO UNDERSTAND ONLY A FEW QUESTIONS

The respondent:
1 COULD HEAR VERY WELL
2 COULD HEAR FAIRLY WELL
3 COULD NOT HEAR WELL AT ALL

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KEN W. SHULMAN
MILES SIEGEL

[illegible]
BERNARD KAPLAN

December 14, 1978

The Honorable James M. Stone
Commissioner of Insurance
100 Cambridge Street
Boston, Massachusetts 02202

Re: Special Market Conduct Examination of
Union Fidelity Life Insurance Corporation

Dear Commissioner Stone:

I respectfully submit the following information and exhibits. The information contained in this letter and the enclosed exhibits represents the results of the special market conduct examination. The contents of the exhibits are summarized below.

A. Sales, Advertising and Promotional Materials. The principal bodies of law governing the form and content of sales, advertising and promotional practices in the Commonwealth of Massachusetts are Massachusetts General Laws Chapters 93A, 175 and 176D and the rules and regulations promulgated thereunder. All reflect basic concepts of fairness and full disclosure. This is more fully discussed in Exhibit 1, which is a memorandum of law setting forth the legal authorizations upon which the following standards of review and apparent violations are based.

In summary, advertising capable of being interpreted in a misleading way should be construed against the advertiser. One should look not only to the literal meaning of words used, but also to all that is reasonably implied. The team in this examination has employed its expertise to evaluate an advertisement as it would appear to the general public, which includes many persons who are of limited experience, education or training and who are not conversant with health and insurance needs and resources. It is a fact of the marketplace that many who make purchases do not or cannot stop to analyze fully the advertising claims. All too often decisions are governed by appearances. Advertising practices may violate Commonwealth regulations not only where there is proof of actual deception, but also where representations have a capacity or tendency to deceive. Many times advertising innuendo induces misunderstanding or deception as surely as outright false statements.

In order to evaluate the completeness and fairness of advertising and promotional materials, it is necessary to know all that is relevant to the subject matter of the advertising, including much information which is omitted from the actual advertisements. To accomplish the evaluation, it was necessary to acquire and analyze extensive information concerning the costs of medical treatment, the courses of treatment and the development of various diseases and health care resources available to the general public. This is a task which is virtually impossible for the overwhelming majority of the general public. The enormity of the task underscores the need for full and fair disclosure in company advertising. It is apparent that between the company and the consumer, only the company has the realistic opportunity and the economic and reference resources available to perform such a task.

The team, because of time limitations, did not conduct a thorough review of each and every piece of advertising literature promulgated or utilized by the Company during the past few years. The team did conduct a thorough item-by-item review of selected promotional materials, particularly those relating to cancer and Medicare supplements. The general findings and conclusions were then compared with the results of an abbreviated examination of every piece of literature to determine if the specific findings of the thorough review were indicative to overall Company advertising practices. The conclusions and observations reached about cancer and Medicare are representative of many of the Company's advertising materials and the specific statutory violations set forth in Exhibits 2, 3 and 5 are applicable to other materials not so thoroughly reviewed.

Exhibit 2 is a legal review of the promotional materials utilized by the Company in the sale of its Basic Cancer Benefit Insurance Policy. The Famous People Advertising Brochure is only one of many utilized by the Company, but the apparent violations found are typical in kind to those found in other cancer promotional materials. Exhibit 3 is a legal review of the promotional material utilized in the sale of the Company's Cancer Extras Rider and Cancer Increase Rider. The apparent violations set forth are also typical of violations found in other cancer-related promotional materials.

Exhibit 2 lists in excess of 90 apparent violations of Massachusetts laws for the particular advertising brochure reviewed. The apparent violations are representative, and not exhaustive, of violations related to the cancer benefit policy. In summary, the brochures failed to include sufficient material and relevant information to permit the consumer to make a meaningful and informed decision concerning the adequacy and appropriateness of the insurance policy promoted. The information omitted includes, but is not limited to, average individual costs of cancer treatment, courses of treatment of cancer, company loss ratios (benefits paid/premiums received) and relationship to other insurance available to the consumer. As a result, the reviewed advertising was not sufficiently clear and complete to avoid deception or the capacity or tendency to mislead or deceive the consumer. The brochures reviewed contain numerous half-truths or ambiguous statements which contribute to the capacity or tendency of the materials to mislead or deceive. n some cases, because of the time limit and the benefit structure of the licy, it is literally impossible for the policy holder to collect benefits advertised. In other cases, because of the usual course of cancer treat- t and general hospital practices, it is highly improbable, but not literally ssible, that full benefits will be paid. In any case, the sale of the ct policies is unconscionable when viewed by accepted legal standards.

The same general comment can be made concerning the apparent violations found in Exhibits 3 and 5. Exhibit 3 lists in excess of 120 apparent violations of Massachusetts law. Exhibit 5 is a review of the Medicare Supplement Insurance Plan marketed through the Senior Citizen Group Insurance Trust. Exhibit 5 lists approximately 69 apparent violations found in the reviewed materials. In all cases, the acts or practices represented by the apparent violations set forth in Exhibits 2, 3 and 5 would violate Massachusetts General Laws Chapters 93A, 175 and 176D.

B. Insurance Policy and Application Forms. The public policy of the Commonwealth with regard to the required contents of health insurance policies and applications is best stated in the regulations themselves. That policy is "to provide reasonable standardizations and simplification of the terms and coverages...to facilitate public understanding and comparison...to eliminate provisions which may be misleading or confusing and to provide full disclosure." The standards found in the regulations are intended to provide the consumer with a meaningful and informed basis for making decisions concerning the acquisition and retention of health insurance. Exhibit 4 is a review of the Basic Cancer Benefit Insurance Policy and riders which are marketed by the Company. Exhibit 6 is a review of the seven-star Medicare Supplement Insurance Policy which is marketed by the Company. These two policies are the principal forms in use by the Company for the sale of Cancer and Medicare Supplement Policies. Exhibit 4 indicates 20 apparent violations in the Basic Cancer Benefit Policy form. Exhibit 6 indicates 13 apparent violations in the Medicare Supplement Insurance form.

If additional comments or documentation is required, please do not hesitate to contact me.

Very truly yours,

Arthur J. McCabe, II

AJM:pmb

Enclosures

SPECIAL MARKET CONDUCT EXAMINATION
OF
UNION FIDELITY LIFE INSURANCE COMPANY

* *

EXHIBIT 1

Memorandum of Law

* * * * *

EXHIBIT 2

Career Famous People Advertising Brochure

* * * * *

EXHIBIT 3

Cancer Extras Rider and Cancer Increase Rider

* * * * *

EXHIBIT 4

Cancer Benefit Policy and Riders

* * * * *

EXHIBIT 5

Medicare Supplement Insurance Plan

* * * * *

EXHIBIT 6

Medicare Supplement Policy

December 14, 1978

EXHIBIT 1

MEMORANDUM OF LAW

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Applicable Law.	2
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EXHIBIT 1

MEMORANDUM OF LAW

LEGAL STANDARDS APPLICABLE TO MARKETING PRACTICES

Introduction

The Commonwealth of Massachusetts has established explicit minimum standards against which all marketing and sales practices and methods of competition of insurance companies are measured. These standards apply not only to the form and content of the insurance policies and promotional materials utilized therewith, but also to all other acts and practices which the insurance company may employ in its dealings with the consumer. In very general terms, "Fairness" in the marketplace is the underlying concept upon which all consumer protection statutes and regulations are based. This concept of fairness includes but is not limited to consideration of such factors as relative bargaining position of the company and the consumer, access to relevant information upon which decisions can be based, alternatives available to the consumer and the relative costs thereof and, of course, compliance with specific Commonwealth Laws and Regulations.

There are two general areas of review in examining the marketing approach of a particular company as it is measured against Consumer Protection Laws. The first involves a review of all the individual pieces of advertising and promotional materials and specific insurance policies and riders thereto to determine that all the materials reasonably comply with appropriate laws and regulations governing such materials and to determine that the promotional materials are complete, contain all material facts and are presented in a writing style in such a manner that the consumer can make a reasonably informed decision. This, of course, requires that all promotional materials reasonably reflect all significant insurance policy provisions and are consistent with the policies they promote. It also requires a review of the authenticity, content and fairness of all factual representations included in the promotional materials. This first area of review generally utilizes existing statutes and rules and regulations and is usually performed in a piece-by-piece manner. This area generally involves an interpretation of the letter of the law.

The second area of major concern is of much broader nature and involves an examination of the spirit and intent of the law. This area of review is conducted from a much broader perspective and it requires an examination of overall company philosophies, approaches and techniques and it ultimately requires an overall evaluation of the basic worth of the company's products. Violation of these areas of the law are of a much greater significance to the Division because they are much less susceptible to corrective action by the company and have the potential of doing the greatest harm to the citizen of the Commonwealth. It is possible to have violations of the former area without violations of the latter. The converse is also true.

Applicable Law

The principal bodies of law governing the form and content of sales, advertising and promotional materials are Massachusetts General Laws Chapter 176D, Section 3 and the regulations promulgated thereunder; Massachusetts General Laws Chapter 175, Section 110E and the regulations promulgated thereunder; and Massachusetts General Laws Chapter 93A, Section 2 and the regulations promulgated thereunder. Chapter 93A is the Consumer Protection Act. In summary, all reflect the basic concepts of fairness and full disclosure enunciated earlier in this report.

Discussion

The Massachusetts Consumers Protection Act, M.G.L. Chapter 93A, prohibits unfair and deceptive acts and practices in the conduct of any trade or commerce. When dealing with the insurance industry in particular, Chapter 93A must be read in conjunction with M.G.L. Chapter 175, Section 110(E) and M.G.L. Chapter 176D, Section 3. These sections enumerate those practices of the insurance industry which the legislature had determined to be unfair and deceptive. As we have seen in the preceding memoranda, several of Union Fidelity's practices meet these criteria.

Section 2(b) of Chapter 93A requires the courts of the Commonwealth in construing Section A to also be guided by the interpretation given by the Federal Trade Commission (FTC) and the Federal Courts to Section 5(a)(1) of the Federal Trade Commission Act, 15 U.S.C.A. 45(A)(1), which, like Chapter 93A, prohibits unfair and deceptive trade practices. In addition to the laws of the Commonwealth of Massachusetts, which enumerate those practices of the insurance industry which are considered unfair and deceptive, the FTC and the Federal Courts have sought to determine what constitutes an unfair and deceptive trade practice by first establishing standards of fundamental fairness and then looking to see if a particular act is contrary to those standards.

An act or practice or representation is a "deceptive" act or practice if it has the "capacity" or "tendency" to deceive. Intent to deceive or actual deception need not be proven or found. FTC v. Sterling Drug, Inc., 317 F.2d 669 (2nd Cir. 1963); Montgomery Ward Co. v. FTC, 379 F.2d 666 (7th Cir. 1967). The test is whether the natural and probably result of the challenged practice is to cause one to purchase that which he did not intend to buy. Indiana Quatered Oak Co. v. FTC, 26 F.2d 340 (2nd Cir. 1928); Brockenstette v. FTC, 134 F.2d 369 (10th Cir. 1943). In determining whether a representation is deceptive, its effect upon the "ordinary" purchaser, the public, or the "average" man is considered. In the performance of this review, it is the effect upon the so-called "average" person within the segment of the public to which the advertising is directed. The law is not made for experts, but rather to protect the public, which includes the ignorant, the unthinking, the credulous and the less sophisticated, who, in making purchases, do not stop to analyze, but too often are governed by appearances and general impressions. Aronberg t.a. Positive Products Co. v. FTC, 132 F.2d 165 (7th Cir. 1943). Whether or not an advertisement is deceptive must be determined from the overall impression it conveys. This includes not only what is said, but also what is not said and what may reasonably be implied. Spiegel v. FTC, 411 F.2d 481 (7th Cir. 1969). It is immaterial that the given phrase, when considered technically, might be construed so as not to constitute a misrepresentation. Country Tweeds Inc. v. FTC, 326 F.2d 144 (2nd Cir. 1964). Statements susceptible of both misleading and truthful interpretation will be construed against the advertiser. Murray Space Shoe Corp. v. FTC, 304 F.2d 270 (2nd Cir. 1962).

Such advertising is deceptive. Rhodes Pharmacal Co. v. FTC, 208 F.2d 382 (7th Dir. 1953) rev'd on other grounds, 348 U.S. 940 (1955). Non-disclosure of material facts which fails to "present the consumer an opportunity to make an intelligent choice" is deceptive. J.B. Williams Co. v. FTC, 281 F.2d 884 (6th Cir. 1967).

It is well settled in Massachusetts that Chapter 93A has wholly incorporated the standards of interpretation developed by the Federal Trade Commission Act. Citing Federal Trade Commission v. Sperry & Hutchinson Co., 405 U.S. 233 (1972), the Supreme Judicial Court has held that the considerations to be used in determining whether a practice is to be deemed unfair include:

> "(1) whether the practice...is within at least the penumbra of some common-law, statutory, or other established concept of unfairness; (2) whether it is immoral, unethical, oppressive, or unscrupulous; (3) whether it causes substantial injury to consumers (or competitors or other businessmen). If all three factors are present, the challenged practice will surely violate Section 5...if it is exploitative or inequitable and if, in addition to being morally objectionable, it is seriously detrimental to consumers or others."

In order to illustrate how this standard is applied in an insurance case, one could look at the case of American Life and Accident Insurance Co. v. FTC, 255 F.2d 289 (8th Cir. 1958), which is factually similar to the present case and has been cited often in late manner. In that case, the petitioner was an insurance company organized under the laws of the State of Missouri, but just like Union

Fidelity, did an extensive mail order insurance business in other states. The advertising matter in question pertained to American's hospitalization and surgical policy called the "Provider" or "New Provider" policy which provided indemnity for loss of life by accidental bodily injury, for hospitalization and surgery due to sickness or accident, and through the use of various riders it could be modified or enlarged to cover a variety of contingencies. When the name of a prospective customer was received, the company would send to that customer a form letter, which was always accompanied by a brochure describing the policy, two application forms and a return envelope. At times other advertising materials describing benefits were mailed. This was especially so if no reply was forthcoming. In addition, the brochure contained favorable comments from policyholders. This is similar to Union Fidelity's policy of including a brochure with pictures of celebrities who have contracted cancer, and statements by policyholders attesting to the excellence of Union Fidelity's policy. Just as with the Union Fidelity policy, the American policy required no medical examination.

In reviewing American's policy, the FTC found the advertising of petitioner violative of the Federal Trade Commission Act in the following ways:

(1) That it misrepresented the amounts paid as benefits;

(2) That it misrepresented the extent of coverage;

(3) That it misrepresented that, except for specific stated limitations, the policies provided indemnification for losses or expenses resulting from any sickness or accident, and

(4) That it misrepresented that its policies might be kept in force continuously at the option of the insured.

These four categories of violations are basically the same as those committed by the Union Fidelity policy. The Commission found all these practices to be false and misleading and ordered remedial action.

The Supreme Judicial Court in Massachusetts has clearly stated that such standards of review apply to insurance company practices. Dodd v. Commercial Union Ins. Co., 365 N.E.2d 802 (1977). The court has also stated that activities of defendant may be investigated outside of the Commonwealth as long as they are relevant to alleged violations of law within the Commonwealth. In the Matter of a Civil Investigative Demand Addressed to Yankee Milk, 362 N.E.2d 207 (1977). Finally, the court has approved of restitution as an appropriate remedy under Chapter 93A, Commonwealth v. DeCotis, 366 Mass. 234, 316 N.E.2d 748 (1974).

Conclusion

In view of the foregoing, it is clear that Commonwealth and Federal standards of legal review of advertising require full and fair disclosure of all material facts which might influence a consumer in making his or her decision concerning the acquisition of insurance. Furthermore, it is clear that broad powers of investigation and enforcement are available where the law is apparently violated. This includes class action remedies under certain circumstances.

EXHIBIT 2

CAREER FAMOUS PEOPLE ADVERTISING BROCHURE

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II. Analysis of Benefits Payable under Cancer Benefit Policy	2
III. Legal Analysis	4-32

EXHIBIT 2

Career Famous People Advertising Brochure

I. Subject Matter and Approach

Items Reviewed: Cancer Famous People Promotional Brochure ($150,000)
UFLIC Form Number LBA 139-B

Underlying Insurance Policy: Cancer Benefits Policy
UFLIC Form Number 2140-20 ($100,000)

Filed for Approval in the Commonwealth: October 29, 1974

Approval by the Commissioner: November 26, 1974

Source: UFLIC Mass. Mailing Project 8-M-46-MR
4211 pieces of mail issued March 20, 1978 and March 21, 1978

Other plans available utilizing similar Brochures: $100,000 Plan; $200,000 Plan

Previous Similar Mailings Reviewed:

1. UFLIC Project Number 8-M-15-FE
   13,864 pieces mailed February 17, 1978
   20,994 pieces mailed March 3, 1978
2. UFLIC Project Number 7-E-49-JU
   21,264 pieces mailed June 2, 1977 to June 22, 1977
3. UFLIC Project Number 7-M-73-OC
   6,311 pieces mailed September 30, 1977 to October 4, 1977
   8,225 pieces mailed
4. UFLIC Project Number 7-E-25-MR
   8,328 pieces mailed March 28, 1977
5. UFLIC Project Number 7-M-24-MR
   20,750 pieces mailed April 9, 1977
6. UFLIC Project Number 7-E-87-OC
   6,118 pieces mailed October 17, 19, and 20, 1977
7. UFLIC Project Number 8-M-43-MR
   27,758 pieces mailed March 20 and 21, 1978

Total pieces mailed March 28, 1977 to March 21, 1978: 133,612

It appears from the results of the market survey that the segment of the public to which this insurance policy is directed consists primarily of elderly citizens. The conclusions set forth below are based in part upon the impression and impact the advertising material will have upon these citizens.

II. Analysis of Benefits Payable under Cancer Benefit Policy $150,000

Maximum Benefits Payable: $150,000 **Premium for Individual Plan:** $ 4.40/month
$52.80/year

In-Hospital Benefits

Hospital Confinement (must be overnight resident in qualified hospital) (periods separated by less than 30 days are considered one confinement period)

90/day	1-7 days	$ 630
60/day	8-90 days	$4,980

Total Available. $5,610

Physician

Actual charges up to $15/day. Physician cannot be surgeon who performs surgical procedures.

$15/day to a maximum of $900 . . . . $ 900

Nursing

Must receive full-time and private care and attendance other than that regularly furnished by the hospital and only when authorized and requested by a legally qualified physician and surgeon. Actual charges up to $36/day.

$36/day to a maximum of $900. . . . . $ 900

Drugs and Medicines, including Chemotherapy

10% of hospital confinement charges to $375. The policy makes no mention of chemotherapy. The policy pays actual charges only if they are less than 10% of hospital confinement. To collect maximum drug benefits one must be a resident in a hospital for 59 consecutive days. Furthermore, chemotherapy, if it is covered under this section, usually is taken on an out-patient basis at hospitals; thus, it would not be covered in any case.

Maximum Available

In and Out of Hospital Benefits

Surgical Benefits

$45-750 per operation. Out of the 40 surgical procedures listed in the policy, only four procedures provide the full $750. The average is less than $450. Multiple surgical procedures through the same incision are treated as one procedure. Although there is technically no limit on the number of operations, sound medical practice would place a physical limit on the number of operations a patient could undergo during a 3-year period. $750

Anesthesia **Maximum Available**

The policy will pay actual charges up to $105 for an anesthesiologist as long as the anesthesiologist is not regularly employed by the hospital. Most hospitals have at least one on staff. $105

Blood and Plasma

The policy will pay actual charges up to $450, but it excludes credits for replacement blood donated on behalf of the recipient. $450

X-Ray - Radiation - Cobalt Therapy

The policy will pay actual charges up to $1,500, but it will not cover diagnostic X-ray or other diagnostic procedures or laboratory tests related to these treatments, nor does any other provision of the policy cover these. $1,500

Ambulance

The policy will pay actual charges up to $75 for each confinement period (2 visits separated by less than 30 days are treated as one) for ambulance trips to and from the hospital if the patient stays overnight at a qualified hospital. To collect maximum benefits a policyholder must be confined 10 times during a 3-year period, with each confinement being separated by more than 30 days. $750

MAXIMUM TOTAL REGULAR BENEFITS: $11,340

Remaining Benefits to be collected under Extended Hospital Benefits Charges $138,660

Extended Hospital Benefits

Cancer diagnosed during the first 120 days during which the policy is in effect is not covered for two years. The policy will pay 100% of usual and customary charges up to $250/day for Hospital Confinement and drugs and medicine benefits. To collect, assuming the usual and customary charges are $250 or more, the patient must be confined 555 days consecutively.

The total number of days covered is 3 years from the date of diagnosis, minus 90 days covered under regular benefits, or 1005 days.

If the usual and customary charges are less than $137.97 per day, it is literally impossible to collect maximum benefits.

(Under the $200,000 Plan, the average daily rate must be greater than $184/day in order to collect maximum benefits.)

III. Legal Analysis

Regulation governing Advertisement of Accident and Sickness Insurance Promulgated in Accordance with M.G.L. c.175, Section 109.

A. Regulation 1-74, Sections 5(a) and 5(b) - Form and Content of Advertisements:

> "Section 5. Form and Content of Advertisements
>
> A. The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.
>
> B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used."

For the purposes of this review and for compliance with the sections of Regulation 1-74, the following guidelines were observed:

1. An advertisement is sufficiently complete if it includes all material and relevant facts and statements indicating applicable exceptions, reductions and limitations to permit the consumer to perform a meaningful analysis of its content and derive an accurate understanding of the underlying policy.
2. An advertisement is sufficiently clear if it states all material and relevant facts and statements in an unambiguous and concise form capable of being reasonably read and interpreted in only one way.
3. An advertisement has the capacity to mislead or deceive if it includes statements which, though reasonably clear and complete in context, could be misunderstood or misconstrued if taken out of context or if the wording or sequence thereof were slightly altered.
4. An advertisement has the tendency to mislead or deceive if it is not reasonably clear or complete as written.

Apparent Violations

Page 1 of the Advertisement (attached hereto)

Violation 1: The policy is designated $150,000 Cancer Plan. This designation is misleading and deceptive because it is virtually impossible for the consumer to collect benefits to or approaching the policy limit. The company is or should be aware of this impossibility. First, the company's own loss ratio and claims payment history is indicative of this conclusion. Second, the benefits and risks covered under the policy are inconsistent with actual medical experience in the treatment of the various forms of cancer. In order to collect the available benefits in full, the consumer would have to have cancer diagnosed more than 120 days after policy issuance and, in the 36- month period immediately after diagnosis, be confined to a qualified hospital for a minimum period of 555 consecutive days. Because the policy pays only actual costs, if the daily hospital charges are less than $138, it is literally impossible to collect the maximum.

Violation 2: The format of page 1 gives the appearance of being a certificate of eligibility. This certificate has the tendency to mislead or deceive the consumer into believing that he or she has been specially selected to apply for this coverage and that he or she is automatically eligible. This is not true, as most recipients of the certificate are selected only because they appear on a mass-mailing list purchased or acquired by the company. The individuals appearing on these lists are not individually screened nor are they selected on the basis of predetermined standards of eligibility. Further, their eligibility is not guaranteed in that each recipient of the certificate is subject to rejection because of pre-existing conditions as would any other consumer applying for this policy.

Violation 3: The seal on the lower right hand corner of the certificate has the capacity to mislead or deceive. The seal, bearing an eagle, stars and stripes, and the words "SECURITY, SERVICE and PROTECTION" is designated "Official Seal." The implication or appearance is that it is associated with or issued by a governmental authority. The seal is meaningless and it is not issued or approved by or under the authority of any governmental or private agency or association.

Violation 4: The certificate offers a free gift if the application is mailed by a certain date. The so-called "free gift" is merely an incentive to apply promptly. In fact, it is merely part of the promotional material and some form of free gift is offered or given to all mass-mailing applicants regardless of the time they apply. Consequently, the deadline date given and the implication that a free gift is dependent upon a prompt response by the consumer are illusory. Thus, the consumer may be misled or deceived.

Violation 5: The statement "...provides benefits for cancer treatment in addition to any group insurance plan or Medicare" is misleading and deceptive because if these other plans have coordination of benefits provisions, then the benefits offered by the company plan are "instead of" or "in lieu of", rather than "in addition to", these other benefits.

Page 2 of the Advertisement (attached hereto)

Violation 6: In the text of the letter are cited various statistics concerning the number of persons who will be affected by cancer and the costs associated therewith. The statistics are stated as facts. They are not facts, but estimates. The failure to designate them as estimates where they appear in the letter has the tendency and capacity to mislead and to create a false impression.

Violation 7: The letter emphasizes the $15,000 gross benefits available. Because it is highly unlikely, if not impossible, to collect this magnitude of benefits, this emphasis creates a false impression which has the tendency or capacity to deceive. (See Violation 1 above.)

Violation 8: The statement in the letter, "the rest of the facts about the cancer plan are inside", is not true. There is not a full statement of the extent of the limitations and exclusions stated inside, nor are other facts (such as overall costs, other cancer-related plans available from the company, or loss ratio and claims payment history) stated. All of these omitted facts are material and relevant to the decision to acquire the policy. The omission of these facts renders the advertisement incomplete and has the capacity to mislead the consumer.

Violation 9: The statement in the letter "the cost is reasonable...as little as $3.25/month" is misleading. The $3.25/month figure is the premium for the company's $100,000 plan whereas all other statements in the letter pertain to the $150,000 plan. This has the capacity to mislead the consumer to believe the policy is less expensive than it actually is in relation to the benefits received. Furthermore, the determination as to the reasonableness of the cost can be made only after a sufficiently complete statement of all material facts about the policy benefits and other plans is available. These facts are omitted making the statement deceptive.

Violation 10: A portion of the letter stated "...we're offering you the opportunity to be protected by the UFL $150,000 Cancer Benefit Plan. The plan will pay you cash for cancer treatment both in and out of the hospital. And every penny of the money is paid DIRECT TO YOU..." This statement has the tendency to mislead and deceive. First, it is highly unlikely that the consumer will in fact collect every penny of the benefits (see Violation 1 above). Second, few, if any, of the available benefits cover treatment out of the hospital, yet the statement creates the impression of full coverage in or out of the hospital.

Violation 11: The entire thrust of the letter and the format employed has the tendency to create fear or trepidation in the mind of the consumer with regard to the probability of getting cancer and its subsequent cost. By emphasizing the estimates of the incidence of cancer and by depicting and quoting well-known and respected public figures as being victims of cancer, an atmosphere of fear and anxiety is promoted in which the consumer may be misled about the need for and the benefits of the company's cancer benefit policy. The emphasis placed upon the emotions associated with cancer rather than the actual benefits of the plan has the tendency to mislead.

Violation 12: The so-called "official seal" has the capacity and tendency to mislead and deceive. (See Violation 3 above.)

Page 3 of the Advertisement (attached hereto)

Violation 13: The statistics utilized are taken from the American Hospital Association and the American Cancer Society, are only estimates, and should be designated as such. Furthermore, even as estimates, their use has the capacity to mislead because the estimates fail to cite necessary demographic, occupational, social and environmental factors which create variations in the incident and effect of cancer.

Violation 14: The recitation of the gross economic cost of cancer to the American people is misleading because it fails to state clearly and completely the factors upon which the $3 billion annual cost is based. There is no indication that the $3 billion cost includes many factors such as wage loss and out-of-hospital expenses which are not covered by the cancer benefit policy. The use of the gross economic figure has the tendency to mislead the consumer.

Violation 15: The statement that the "average cancer hospital stay is twice as long as other hospitalization" is misleading and deceptive particularly when it is included in a portion of the text emphasizing the high cost of cancer treatment. The statement is not sufficiently complete because it omits the actual length of a hospital stay due to cancer which, according to a survey by the National Cancer Institute (and others), is between two and three weeks, with a substantial portion of hospitalizations being under thirty days.

Violation 16: The statement that "cancer costs include higher fees for physicians services, drugs, nursing care and sick room equipment" has the capacity and tendency to mislead because it gives no indication as to the actual costs incurred or the base costs against which cancer costs are compared. Furthermore, the inclusion of this statement is deceptive because it implies that all the stated factors are covered by the policy.

Violation 17: All references on this page to $150,000 cancer plan or cancer benefits is misleading and deceptive because the benefits of the policy are set up in such a way as to make it highly unlikely such substantial benefits will be received.

Violation 18: The statement that "all cancer benefits are paid in cash direct to you..." has the capacity to mislead and deceive the consumer. (See Violations 1 and 10 above.)

Violation 19: The recitation of Hospital Confinement Benefits set forth within the section entitled "Cancer Benefits Summary" has the capacity to mislead because the reduction of benefits after the first seven days is set forth in smaller print than that used to indicate the increased benefits for the first seven days. The statement is not sufficiently clear and complete to avoid deception because it fails to include both the restrictive definition of hospital confinement, found in the underlying policy, and the restrictions on the type of institution covered, found in the exceptions and limitations portions of the policy and the advertisement. It also fails to include any reference thereto.

Violation 20: The recitation of physicians benefits has the capacity to mislead and it is not sufficiently clear and complete to avoid deception because it is unclear whether the coverage is for actual physician charges up to a limit or whether there is a flat sum paid regardless of actual charges. The policy appears to provide for payment of a flat sum. It is also unclear from a comparison of the policy to the advertisement whether the exclusion of charges by the surgeon performing surgery is applicable only to those charges directly associated with the surgery or whether all charges by said physician are excluded if he or she also happens to be the surgeon performing surgery.

Violation 21: The recitation of nursing benefits has the capacity to mislead and it is not sufficiently clear and complete to avoid deception. First, it is unclear whether the payment is of actual charges or a flat sum (see Violation 20). Second, it fails to include or refer to the restrictive definition of in-hospital nursing services found in the policy.

Violation 22: The recitation of benefits for drugs and medicines including chemotherapy has the capacity to mislead and is not sufficiently clear and complete to avoid deception. First, because such recitation is stated in terms of a percentage of hospital confinement benefits it is subject to the same criticisms as those set forth in Violation 19. Second, the advertisement makes reference to chemotherapy whereas the policy does not. Third, it appears the policy will pay actual charges up to $375 only if said actual charges are not greater than 10% of the hospital confinement benefits. Thus, a consumer could incur $375 worth of charges in the first week for drugs and be denied a substantial portion of the payment because the actual cost exceeded 10% of the confinement benefits. This limitation is not sufficiently clear to avoid deception.

Violation 23: The recitation of the surgical benefits is unclear and has the tendency to mislead. The benefits cite $45 to $750 per operation, yet the actual benefits set forth in the policy surgical schedule are substantially less than the $750 promised. Of the forty surgical procedures listed in the surgical schedule, only four pay the full amount. The average is less than $450 per surgical procedure; thus, the method of stating benefits is misleading.

Violation 24: The recitation of the Anesthesia benefits is deceptive and incomplete because it fails to state that the anesthesia will not be covered if the anesthesiologist is employed by the hospital.

Violation 25: The recitation of blood and plasma benefits is not sufficiently clear and complete to avoid deception because it fails to include references to any credits the consumer may receive for blood replaced by donors.

Violation 26: The recitation of X-ray, radiation and cobalt therapy benefits is not sufficiently clear and complete to avoid deception because it fails to set forth the exclusion of diagnostic X-rays or other diagnostic procedures or laboratory tests related to this treatment, which exclusion is set forth in the actual policy.

Violation 27: The recitation of ambulance benefits is deceptive and it is not sufficiently clear and complete. It fails to include the restrictive definition of "hospital confinement period set forth in the policy. It also fails to set forth the requirement that the consumer be admitted as a resident patient in order to collect the benefits.

Violation 28: The recitation of extended hospital benefits is not sufficiently clear to avoid deception and it has the capacity and tendency to mislead and deceive. First, it is unclear from the statement that the policy only pays actual charges on a per diem basis. The policy does not pay $7,500/month or $250/day unless said charges are actually incurred on a daily basis. Second, the statement fails to include the limitation that the hospitalization must be within the overall 3-year coverage period of the policy. Thus, a person may be denied benefits before discharge from the hospital and before the full benefits are paid if said hospitalization continues beyond a point three years from the date the cancer was diagnosed. Finally, the statements fail to include any estimate as to what actual hospital charges may be so that the consumer will clearly see that there is a substantial likelihood that full benefits literally cannot be collected under the policy.

Violation 29: The format of the cancer benefits summary is not complete because it fails to include a reasonable statement of limitations and exclusions. It fails to include a clear statement that cancer diagnosed during the first 120 days that the policy is in force is not covered for two years. It fails to state clearly that all benefits terminate three years from the date of diagnosis. Even though these exclusions and limitations are stated and critiqued elsewhere, they should be included in the benefit summary to permit a meaningful analysis by the consumer. The summary entirely omits a clear statement that the benefits are not provided for any other disease, sickness or incapacity even though such disease or incapacity may have been complicated or aggravated by such covered cancer or by the treatment given for such covered cancer.

Violation 30: The offer of a "special free bonus" has the capacity to mislead because it is neither special nor free nor a bonus (see Violation 4).

Violation 31: The format of the entire cancer benefits summary is not sufficiently clear or complete to avoid deception or misunderstanding because it fails to include any estimates or reliable figures as to actual costs which may be incurred by the consumer during the illness, which estimates could be used by the consumer in analyzing and evaluating the coverage offered by the policy.

Page 4 of the Advertisement (attached hereto)

Violation 32: The section beginning "cash paid for all forms of cancer" is not clear or complete and has the tendency to mislead. The policy itself provides strict standards for the diagnosis of cancer which standards do not include "all forms of cancer." The phrase "you collect full benefits" is misleading because it implies collection of the dollar amounts set forth in the policy without reference to the limitations and exclusions which may reduce or even eliminate the actual dollar payments. Although there are no literal requirements of deductibles or co-payment, the consumer generally ends up paying some of the costs incurred because of the numerous limitations and exclusions to which the benefits are subject.

Violation 33: The section "pays cash in and out of the hospital" has the capacity to mislead and deceive because most benefits under the policy require actual hospital confinement overnight.

Violation 34: The section stating "cash paid in addition to any other plan, even group or Medicare" has the capacity to mislead because it fails to alert the consumer as to the likelihood or possibility of coordination of benefits provisions which may reduce overall benefits under such "other group plans" or Medicare. Such disclosure is necessary to insure that the consumer is aware that the benefits under the policy may reduce existing coverage of other plans thereby depriving the consumer of the "additional" cash.

Violation 35: The term "guaranteed renewable for life regardless of physical condition" is deceptive and misleading because the policy will terminate three years from the date any form of cancer is diagnosed, regardless of the course of treatment of the cancer or the form. Even if no actual treatment is required and the cancer recedes, the consumer will not have the right to renew the policy.

Violation 36: The section commencing "full benefits over 65" is misleading. The section pertains to exceptions and limitations and not to benefits per se. Thus, the reference to full benefits over 65 detracts from the purpose of the section. Furthermore, all exceptions and limitations are not set forth, particularly definitions of cancer, confinement period and benefits paid (which are more limited in the policy than they appear in the advertisement).

Violation 37: The representation concerning the policy holder service is misleading and incomplete. Elsewhere in this report is an analysis of the performance of the policy holder service department, which indicates that in many cases there was a substantial delay in the response to questions asked by policy holders.

Violation 38: The statement "one rate same benefits for all ages" is deceptive because during the first year of coverage there is a 120-day waiting period without a corresponding reduction in premium. Although this is the same for all policy holders, it is a delay which is not not clearly stated.

Humphrey Newspaper Article

Violation 39: The use of testimonials is misleading and deceptive because some of said testimonials are quoted out of context and do not pertain to the policy offered for sale.

Violation 40: The use out of context of statements made by Senator Humphrey is misleading and deceptive. (See Violations 6 and 11.) The statement does not cite the newspaper in which the article appeared (The Florida Times-Union of Jacksonville; May 26, 1977), and it is edited in a misleading way because it excludes references to chemotherapy and criticisms of cancer policies.

B. Regulation 1-74, Sections 6(A)(1-8) - Advertisement of Benefits Payable, Losses Covered or Premiums Payable:

"Section 6. Advertisements of Benefits Payable, Losses Covered or Premiums Payable.

A. Deceptive Words, Phrases or Illustrations Prohibited

(1) No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(2) No advertisement shall contain or use words or phrases such as, "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

(3) An advertisement shall not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as, describing a waiting period as a "benefit builder", or stating "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

(4) No advertisement of a benefit for which payment is contingent upon confinement in a hospital or similar facility shall use words or phrases such as "tax free"; "extra cash"; "extra income"; "extra pay"; or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

(5) No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

(6) No advertisement of a policy covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(7) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following: "THIS IS A LIMITED POLICY"; "THIS IS A CANCER ONLY POLICY"; THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY".

(8) An advertisement of a direct response insurance product shall not imply that because "no insurance agent will call and no commissions will be paid to agents" that it is "a low cost plan," or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product."

Page 1 of Advertisement

Violation 1: The use of certificate of eligibility has the capacity and tendency to deceive prospective purchasers as to their selection for receipt of the advertising materials. There are no standards of eligibility on which the company bases its decision to solicit the named individual. The statement that coverage "...is guaranteed to you and members of your family who have not had cancer" is not sufficient to remedy the defect. The fact that the certificate is issued to the named recipient has the capacity to mislead said recipient to believe that the restriction to those who have not had cancer is limited to members of the recipient's family only and not to the recipient himself.

Violation 2: The use of the gold official seal on which is emblazoned an eagle and stars and stripes has the capacity to deceive prospective purchasers to believe that the policy has been approved, reviewed or authorized by an official governmental agency and thus is deceptive as to the nature of the policy.

Violation 3: The emphasis on the inscription "$150,000.00 Cancer Plan" has the tendency to deceive or mislead a prospective or actual purchaser as to the extent of the policy benefits payable and tends to exaggerate the likely benefits beyond the term of the policy.

Violation 4: The omission of a clear and conspicuous statement on the certificate of eligibility that the benefits are limited to cancer only and do not cover some expenses of cancer treatment or related treatments is a violation of subsection (7). Many expenses associated with cancer treatment are covered by medicare or group insurance plans which are not covered by this offered cancer plan.

Page 2 of the Advertisement

Violation 5: The use of the pictures of famous deceased people, all of whom had cancer, accompanied by the warning that the same thing could happen to the prospective purchaser, tends to exaggerate the nature and extent of the policy benefits and loss coverage because it fails to indicate whether or not the deaths were caused by cancer which the policy would cover, implies that somehow the policy will provide protection from cancer-related death, and leads to an emotional, rather than functional, response to the need for such policy.

Violation 6: Statements such as "we can guarantee you financial protection up to $150,000.00 to help you beat the disease" are misleading because the benefit structure of the policy is such that it is highly unlikely and in some cases impossible for the policy holder to collect benefits to the extent apparently guaranteed in the letter. The designation of the benefits as protection is misleading because in most cases the policy holder will still have financial obligations and losses which are not covered by the plan.

Page 3 of the Advertisement

Violation 7: The statistics are not clearly identified nor are they sufficiently clear to avoid deception. The omission of the underlying facts on which cancer treatment expenses are computed and analyzed tends to mislead the prospective customer as to the benefits payable and losses covered and to exaggerate the benefits beyond the terms of the policy.

Violation 8: The use of the words "up to $____ per day" tends to exaggerate the benefits beyond the terms of the policy because the policy is an indemnity policy paying actual expenses.

Violation 9: The cancer benefit summary omits information pertaining to restrictions and limitations found in the policy itself which omission tends to mislead the prospective purchaser as to the benefits payable and the losses covered.

Violation 10: The statement "Pays you up to $150,000.00 Cash Benefits" followed by the statement "All cancer benefits are paid directly to you" exaggerates the benefits beyond the terms of the policy.

Violation 11: The recitation of daily benefits payable with regard to extended hospital benefits is deceptive and misleading because it feils to state clearly the limits on the number of days covered and other restrictive definitions of those benefits appearing in the policy.

Violation 12: The use of the illustration of the United States setting forth the estimated cancer cases by state is misleading because it omits information as to factors which make the estimated figures unreliable.

Page 4 of the Advertisement

Violation 13: The pledge of Harry Dozer, that cash is paid for all forms of cancer, is misleading as to the extent of the benefits and exaggerates said benefits beyond the terms of the policy because full benefits are not paid for all forms of cancer due to policy restrictions. In most cases the policy holder, because of actual costs, will be required to incur additional obligations which may require co-payments.

Violation 14: The Pledge "pays cash in and out of the hospital" has the capacity to mislead as to the benefits payable because most benefits are contingent upon hospital confinement.

Violation 15: The Pledge "all benefits paid in cash..." has the capacity to mislead the public to believe that the policy will, in some way, enable them to make a profit from being hospitalized.

Violation 16: The designation "additional cash" has the capacity to mislead the public to believe that the policy will, in some way, enable the policy holder to make a profit from being hospitalized.

Violation 17: The Pledge "Guaranteed Renewability" has the capacity to mislead because it fails to set forth clearly the 3-year time limitation of the policy after the diagnosis of cancer.

Violation 18: The exceptions and limitations pledge omits other substantive limitations in the policy, including restrictive definitions and provisions limiting coverage to actual charges incurred. All limitations, exceptions and reductions are not fairly and accurately described.

Violation 19: The recitation of the premium due omits a clear statement of the 120-day waiting period before immediate coverage is provided, thus having the capacity to mislead the prospective purchaser into believing coverage is immediate.

C. Regulation 1-74, Sections 6(b)(1-3) and 6(c)(1-3) - Exceptions, Reductions and Limitations; Pre-Existing Conditions:

"B. Exceptions, Reductions and Limitations

(1) When a marketing method refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific benefit, or the loss for which such benefit is payable, it shall be considered misleading and therefore prohibited unless it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the marketing method would have the capacity or tendency to mislead or deceive.

(2) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date benefits being to accrue for such loss, a marketing method which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

(3) A marketing method shall not use the words "only"; "just"; "merely"; "minimum"; or similar words or phrases to describe the applicability of any exceptions and reductions such as: "This policy is subject to the following minimum exceptions and reductions".

C. Pre-Existing Conditions

(1) An advertisement which is subject to the requirements of Section 6B shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "pre-existing condition" without an appropriate definition or description shall not be used.

(2) When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment

of a claim thereunder. This rule prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required.

(3) When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question or statement which reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question or statement substantially as follows:

> Do you understand that this policy will not pay
> benefits during the first ___ year(s) after the
> issue date for a disease or physical condition
> which you now have or have had in the past? ☐ YES

Or substantially the following statement:

> I understand that the policy applied for will not
> pay benefits for any loss incurred during the first
> ___ year(s) after the issue date on account of disease
> or physical condition which I now have or have had in
> the past."

Violation 1: The advertisement fails to include all substantive exceptions, restrictions and limitations affecting the benefits payable under the policy thus giving the advertisement the capacity to mislead. This is primarily true of restrictive definitions of losses covered by the policy.

Violation 2: The use of the certificate of eligibility and the statement thereon that coverage is guaranteed to the named recipient implies that the applicant's physical condition will not affect the issuance of the policy.

Violation 3: The application which is part of the advertisement fails to provide an adequate question or statement reflecting the pre-existing conditions provisions of the policy. The "Representation and Agreement" provision of the application form is not sufficiently clear when viewed in relation to the certificate of eligibility and the impression such certificate may make on the policy holder.

D. Regulation 1-74, Section 7 - Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination:

"When an advertisement refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modifications of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions."

Violation 1: The format of the advertisement is such that the gross amount of benefits payable ($150,000) for cancer treatment is emphasized. The advertisement does not clearly and sufficiently disclose provisions relating to termination and modification of benefits and losses covered and thereby minimizes or renders obscure the qualifying conditions. Restrictive definitions of the various benefits payable are not adequately disclosed nor are the waiting and probationary periods, depending on which cancer is diagnosed, sufficiently clear. The relationship between the 3-year termination period and the policy holder's ability to collect the benefits of the policy is also obscured by the format of the policy.

E. Regulation 1-74, Section 8 - Testimonials or Endorsements by Third Parties:

"A. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement is subject to all the provisions of these rules.

B. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation.

C. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any individual group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement.

D. When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time."

Violation 1: The use of testimonials by the insurer is misleading and deceptive in that some testimonials used are solicited by the insurer, which solicitation is not disclosed. Furthermore, in some cases, the text of the testimonial is taken out of context thereby altering the impression intended.

F. Regulation 1-74, Section 9, A-C - Use of Statistics:

"A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

B. An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or generous" or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in such advertisement."

Violation 1: The use of statistics regarding the cost and incidence of cancer in America followed by a statement of the plan benefits, implies that all costs and incidents are covered by the benefits available under the plan. Such statistics are irrelevant with regard to the plan's benefits.

Violation 2: The newspaper from which the interview with Senator Humphrey was taken is not cited in the advertisement and therefore the reliability of the statistics contained therein is questionable.

Violation 3: The use of a portion of the newspaper interview with Senator Humphrey in which he emphasizes the need for cancer insurance and states the hospital and surgical expenses of his brother, constitutes the use of irrelevant facts because it does not disclose whether said expenditures were typical nor does it break down these expenditures by category. Further, it does not disclose whether said expenditures would be covered by the policy offered.

Violation 4: The use of the "gold official seal" implies that the insurer or policy has been endorsed or approved by an association or other entity. The fact that the gold seal is issued by the company and is meaningless is not disclosed.

G. Regulation 1-74, Section 12(B) - Jurisdictional Licensing and Status of Insurer:

"B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this State or the United States Government."

Violation 1: The use of the gold "official seal" on which is emblazoned the stars and stripes creates the impression that the policy is approved, endorsed or accredited by a division or agency of the United States.

H. Regulation 1-74, Section 15, A-C - Introductory, Initial or Special Offers:

"A. (1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising accident and sickness insurance.

(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than 6 months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application which shall be not less than ten days and not more than forty days from the date that such enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the General Laws for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control.

(3) This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

(4) The phrase "a particular insurance product" in Paragraph (2) of this Section means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

B. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

C. Special awards, such as a "safe drivers' award" shall not be used in connection with advertisement of accident or accident and sickness insurance.

Violation 1: The advertisement directly represents that a special free bonus is available for a limited time and implies, by the use of the certificate of eligibility, that the offer is available only to a specific group when such is not the case. This method is one of the usual forms of advertising by the insurer.

Violation 2: The advertisement and enrollment period for the policy is offered less than six months from the date of the immediately preceding enrollment period.

Regulation 1973 Pertaining to the Marketing of Health Insurance in Accordance with Sections 3 and 11 of Chapter 176D.

I. Regulation 1973, Section 5, A-C. - Form and Content of Marketing Method

"A. A marketing method for a health insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether a marketing method has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the marketing method may be reasonably expected to create upon a person of average education or intelligence, within the segment of a public to which it is directed.

B. Marketing methods shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall be considered misleading.

C. In determining whether a marketing method has the capacity or tendency to mislead, the Commissioner of Insurance may consider as misleading the failure to disclose to a purchaser or a prospective purchaser any fact, the disclosure of which may have influenced the purchaser or prospective purchaser not to enter into the transaction."

Violation 1: The cumulative effect of violations 1-40 cited above, under Regulation 1-74, are violations of Sections 5 A-C of the 1973 Regulation.

J. Regulation 1973, Section 6, A-C - Marketing Methods Addressing the Benefits Payable, Losses Covered or Premiums Payable:

A. Deceptive Words, Phrases or Illustrations Prohibited

(1) It is hereby prohibited to omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(2) It shall be considered misleading to solicit an offer to contract for a health insurance policy without a clear and conspicuous disclosure of the premium rate for such policy.

(3) It shall be considered misleading and therefore prohibited for a marketing method of a policy any of whose benefits are conditional upon confinement in a hospital or similar facility, to refer to the benefits or costs of the policy, or the risks against which the policy is intended to provide protection unless it shall also disclose both clearly and conspicuously in accordance with Section 4 as well as on the application for such policy the extent (expressed as % of bills paid) to which the policy meets the costs of the short, average and long hospital stays defined in the attached Appendix A. 'Massachusetts Division of Insurance Hospital Cost Standards.'

(4) It shall be considered misleading and therefore prohibited for a marketing method to contain or use words or phrases such as "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help pay your hospital and surgical bills"; "this policy will help fill some of the gaps that Medicare and your present insurance leaves out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

(5) It shall be considered misleading and therefore prohibited for a marketing method to present descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as, describing a waiting period as a "benefit builder", or stating "even pre-existing conditions are covered after two years." Words and phrases used in a marketing method to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

(6) No marketing of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax free"; "extra cash"; "extra income"; "extra pay"; or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy is a disability or loss-of-time policy or will, in some way, enable them to make a profit from being hospitalized.

(7) It shall be considered misleading and therefore prohibited for the marketing of a hospital or similar facility confinement benefit to state that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit must be stated in the marketing method.

(8) It shall be considered misleading and therefore prohibited for a marketing method of a policy covering only one disease or a list of specified diseases to imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(9) A marketing method for a policy providing benefits for specified illnesses only such as cancer or for specified accidents only, such as automobile accidents, shall be considered misleading and therefore prohibited unless it shall clearly and conspicuously state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following: "THIS IS A LIMITED POLICY"; "THIS IS A CANCER ONLY POLICY"; "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY".

(10) It shall be considered misleading and therefore prohibited for the marketing method of a direct response insurance product to imply that because "no insurance agent will call and no commissions will be paid to agents" that it is "a low cost plan" or use other similar words or phrases because the cost of advertising and servicing such policies is

a substantial cost in the marketing of a direct response insurance product, unless such is the fact, and is clearly substantiated in such advertising.

(11) It shall be considered misleading and therefore prohibited for a marketing method to use photographs, illustrations, depictions or fictionalized accounts of illness or illness related subjects, or overemphasis of exceptional or catastrophic risk, or exaggeration of potential out-of-pocket costs of health care, or any other marketing method in such a way as to invite the purchase of health insurance for emotional rather than functional reasons.

(12) When a policy is marketed whose benefits are intended to supplement and not duplicate those of Medicare, it shall be deemed misleading and therefore prohibited to market such a policy unless the benefits of the policy are prominently disclosed using the following scheme of characterization:

A. In-patient Hospital Benefits
B. In-patient Physicians Benefits
C. Out-of-Hospital Benefits
D. Benefits in Extended Care Facilities
E. Benefits in Nursing Homes
F. Other Benefits

In general the disclosure of benefits in each category will include at least:

1. the extent to which MEDICARE deductibles are covered;
2. the extent to which the co-insurance portions of MEDICARE are covered;
3. the extent to which no benefits are payable.

In disclosing the benefits provided, all of the above categories (A-F) shall always be portrayed, whether or not benefits are provided in those categories. When no benefits are provided in a given category -- statements such as "No In Patient Doctors Benefits Provided", "No benefits in Nursing Homes Provided", "No other benefits provided" must be used.

The disclosure required herein shall be made both in compliance with Section 4 of this regulation and on the application used in soliciting an offer to contract for such a policy. Compliance with this section for Medicare supplement policies shall be deemed as a proper substitute for both the application disclosure requirements of Section 7A and the disclosure requirements of Section 6A (3).

"B. Exceptions, Reductions and Limitations

(1) When a marketing method refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific benefit, or the loss for

which such benefit is payable, it shall be considered misleading and therefore prohibited unless it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the marketing method would have the capacity or tendency to mislead or deceive.

(2) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date benefits being to accrue for such loss, a marketing method which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods or be considered misleading and therefore prohibited.

(3) A marketing method shall not use the words "only"; "just"; "merely"; "minimum"; or similar words or phrases to describe the applicability of any exceptions and reductions such as: "This policy is subject to the following minimum exceptions and reductions" or it shall be considered to be misleading and therefore prohibited.

C. Pre-Existing Conditions

(1) A marketing method shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy or it shall be considered misleading and therefore prohibited. The use of the term "pre-existing condition" without an appropriate definition or description shall not be used or it shall be considered misleading and therefore prohibited.

In this regard it shall be considered misleading and therefore prohibited to define the nature of "pre-existing condition" exclusions using such terms as "manifested, contracted and commenced" or the like without a clear and unambiguous explanation of the operational meaning of such terms accurately reflecting the company's claim practice in denying claims for this reason.

(2) When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder or it shall be considered misleading and therefore prohibited. This rule prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue". If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required or it shall be considered misleading and therefore prohibited.

Violation 1: The cumulative effect of Violations 1-19 under Section 6A of [illegible]-74 and Violations 1-3 of Sections 6B-C are violations [illegible] Section 6 A-C of Regulation 1973.

Violation 2: The marketing method employed in the advertisement overemphasizes the exceptional or catastrophic risk and exaggerates the potential out-of-pocket cost of cancer treatment, especially in view of the benefits offered, so as to invite the purchase of the policy for emotional rather than functional reasons (subsection 11).

Violation 3: The policy is offered to he in addition to and therefore supplemental to Medicare. The Disclosure, therefore, is inadequate because it fails to divulge the extent to which Medicare deductibles are covered; the extent to which the co-insurance policies of Medicare are covered; and the extent to which no benefits are payable (subsection 12).

Violation 4: The benefits are inadequately disclosed because they fail to utilize the required categories of benefits, to wit: Benefit in Extended Care Facilities, Benefits in Nursing Homes and Other Benefits (subsection 12).

K. Regulation 1973, Section 7 - Form and Content of Application:

"When a person uses an application form to be completed by the applicant as an offer to contract for a health insurance product, such application form shall contain statements disclosing to the applicant the nature of the policy offered for sale. In complying with this section of the regulations the following guidelines as to the contents and applicability of disclosure requirements shall be used:

(A) If the application is used for a policy any of whose benefits are contingent upon hospital confinement and where benefits payable represent less than 50% of the cost of an average hospitalization as specified in the Massachusetts Hospital Cost Standards then the following statement must appear on the application: (Not applicable to MEDICARE supplements -- See Sec. 6A (12).)
"This policy is supplemental in its coverage and is meant to be purchased in addition to basic health insurance. This policy pays for (Statistic supplied by marketer) % of the cost of an average stay in a Massachusetts Hospital as defined by the Mass. Division of Insurance Hospital Cost Standards."

(B) If the advertised policy contains a provision which allows the insurer to deny claims for any loss, where the cause of such loss is in some manner traceable to a condition existing prior to the effective date of the policy the application shall state clearly and unambiguously in negative terms the nature and extent of that exclusion in accordance with guidelines spelled out in Sec. 6C (1).

(C) If the application is for a policy whose benefits are subject to a waiting period either of the deductible kind e.g. "5th day for sickness" or of the one-time exclusionary kind, "30 day" or "6 months for certain conditions", the application must disclose in negative terms the nature of such exclusion.

(D) The application must disclose for all health policies whether or not and to what extent benefits are or are not contingent upon hospital confinement.

(E) The application must disclose the premium rate for the policy being solicited.

(F) The application must disclose clearly and unambiguously the terms of renewability and premium guarantee if any.

(G) At the completion of the above required statements of disclosure, space shall be made for the applicant's signature acknowledging understanding of such disclosures.

Violation 1: The application fails to include the required statement concerning actual hospital costs as defined by the Massachusetts Division of Insurance Hospital Cost Standards.

Violation 2: The application fails to state clearly and unambiguously in negative terms the nature and extent of the exclusion for pre-existing conditions or conditions diagnosed within the first 120 days of coverage.

Violation 3: The application fails to disclose the extent to which benefits are contingent upon hospital confinement.

Violation 4: The application fails to adequately disclose the premium rate for the policy solicited.

Violation 5: The application fails to adequately disclose the terms of renewability and premium guarantee.

. Regulation 1973, Section 8 - Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination:

"When a marketing method refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modification of reasons, in a manner which shall not minimize or render obscure the qualifying conditions or it shall be considered misleading and therefore prohibited.

In this regard where there is a guarantee of renewability and/or premium which is conditional either on renewal of all such policies or premium adjustment on all such policies it will be considered misleading unless the marketing method clearly and conspicuously discloses that the insurer has the right to non-renew or to change premium levels at its choice and without specific approval of any state authority."

Violation 1: Violation 1 under Regulation 1-74, Section 7 is a violation of Regulation 1973, Section 8.

M. Regulation 1973, Section 9, A-D - Testimonials or Endorsements by Third Parties:

"A. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement is subject to all the provisions of these rules.

B. If the person making a testimonial, an endorsement or an appriasal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation.

C. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any individual group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement.

D. When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time."

Violation 1: The cumulative effect of Violations 1-4 of Regulation 1-74, Section 8 is a violation of Section 9 of Regulation 1973.

N. Regulation 1973, Section 10 - Use of Statistics:

"A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

B. An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or generous" or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in such advertisement."

Violation 1: The cumulative effect of Violations 1-2 of Regulation 1-74, Section 9 is a violation of Section 10 of Regulation 1973.

O. Regulation 1973, Section 13 C - Jurisdictional Licensing and Status of Insurer:

"C. A marketing method shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this State or the United States Government or it shall be considered misleading and therefore prohibited."

Violation 1: Violations of Regulation 1-74, Section 12(B) is a violation of Section 13 C of Regulation 1973.

P. Regulation 1973, Section 16, A-C - Introductory, Initial or Special Offers

"A. (1) A marketing method for an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact or it shall be considered misleading and therefore prohibited. A marketing method shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer used such enrollment periods as the usual method of marketing accident and sickness insurance or it shall be considered misleading and therefore prohibited.

(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than 6 months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period or it shall be considered misleading and therefore prohibited. The marketing method shall indicate the date by which the applicant must mail the application which shall be not less than twenty days from the date that such enrollment period is advertised for the first time. This rule applies to all marketing methods. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control.

(3) This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy marketed because of special advantages available in the policy unless such is fact.

(4) The phrase "a particular insurance product" in Paragraph (2) of this Section means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

B. A marketing method shall not utilize an initial premium rate which is less than that premium rate which would be charged by making a uniform pro-rating of the annual premium or it shall be considered misleading and therefore prohibited.

C. Special awards, such as a "safe drivers' award" shall not be used in connection with the marketing of health insurance or it shall be considered misleading and therefore prohibited."

Violation 1: The cumulative effect of the violations of Regulation 1-74, Section 15 A-C is a violation of Section 16 of Regulation 1973.

Attorney General's Regulations Promulgated Pursuant to Massachusetts General Laws, Chapter 93A, Section 2(c)

Q. Regulations of the Attorney General, Regulation I.B.

"B. No statement or illustration shall be used in any advertisement which creates a false impression of the grade, quality, make, value, currency of model, size, color, usability, or origin of the product offered, or which may otherwise misrepresent the product in such a manner that later, on disclosure of the true facts, there is a likelihood that the buyer may be switched from the advertised product to another."

Violation 1: The emphasis on the gross dollar amount of benefits payable without a clear and complete statement of limitations, restrictions and exclusions creates a false impression with regard to the quality of the product offered. Once the facts are disclosed, including the fact that, as part of its marketing method, the company routinely attempts to solicit additional business from present policy holders by selling riders or switching the policy holder to other policies sold by the company, there is a likelihood that the buyer may be switched from the advertised policy to another.

R. Regulations of the Attorney General, Regulation IV.A. and B.

"A. No claim or representation shall be made by any means concerning a product which directly, or by implication, or by failure to adequately disclose additional relevant information, has the capacity or tendency or effect of deceiving buyers or prospective buyers in any material respect. This prohibition includes, but is not limited to, representations or claims relating to the construction, durability, reliability, manner or time of performance, safety, strength, condition, or life expectancy of such product, or financing relating to such product, or the utility of such product or any part thereof, or the ease with which such product may be operated, repaired, or maintained or the benefit to be derived from the use thereof.

B. No advertisement shall be used which would mislead or tend to mislead buyers or prospective buyers, through pictorial representations or in any other manner, as to the product being offered for sale. Where price is featured in advertising, any picture or depiction utilized in connection therewith, shall clearly indicate the exact product being offered for sale at the advertised price."

Violation 1: The exaggerated effect of the risks of cancer accompanied by the emphasis on the gross benefits payable, without adequately disclosing limitations and relevant information (such as actual hospital costs), has the capacity and tendency to materially mislead prospective buyers with respect to the usefulness of the policy.

Violation 2: The pictorial representation of cancer facts and statistics together with the statement of policy benefits tends to materially mislead the consumer in the evaluation of the product.

S. Regulation 2-74, Section 20 - Specified Disease or Specified Accident Coverage:

"Policies of individual insurance meeting the definition of Section 12 shall use the following statement only, except that appropriate policy identification may be included:

THE ABC INSURANCE COMPANY

(Specified Disease) (Specified Accident)
Coverage Insured:
Required Disclosure Statement Policy # :

(Specified Disease) (Specified Accident) coverage provides restricted benefits which are payable only in the event of losses from the specified covered diseases (or the specified covered accidents).

This policy provides the following benefits:

Accurately list all benefits.

Read your policy carefully. This disclosure statement is a very brief summary of your policy. The policy itself sets forth the rights and obligations of both you and the insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

Exclusions, Limitations and Reductions. This policy contains the following restriction: (Accurately list all exclusions, reductions and limitations in the policy in a manner which does not encourage misrepresentation of the actual coverage provided).

This policy does NOT provide basic hospital expense, basic medical-surgical expense or major medical expense coverage."

Violation 1: The disclosure form utilized by the company fails to accurately list all benefits and fails to list all exclusions, reductions and limitations in a manner that does not encourage misrepresentation of the actual coverage.

T. Regulations of the Attorney General, Regulation XV.A.-C. - General:

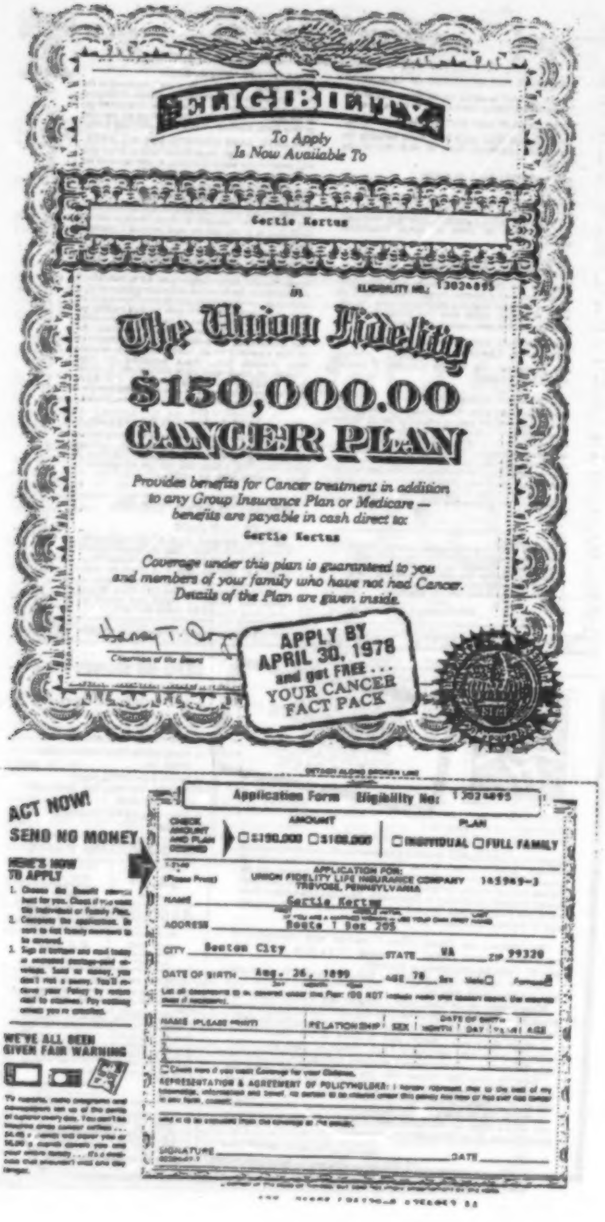
"Without limiting the scope of any other rule, regulation or statute, an act or practice is a violation of Chapter 93A, Section 2 if:

"A. It is oppressive or otherwise unconscionable in any respect; or
B. Any person or other legal entity subject to this act fails to disclose to a buyer or prospective buyer any fact, the disclosure of which may have influenced the buyer or prospective buyer not to enter into the transaction; or
C. It fails to comply with existing statutes, rules, regulations or laws, meant for the protection of the public's health, safety, or welfare promulgated by the Commonwealth or any political subdivision thereof intended to provide the consumers of this Commonwealth protection;"

Violation 1: It is unconscionable to sell a policy which, under certain circumstances, makes it literally impossible to collect the benefits promised.

Violation 2: It is unfair and deceptive to fail to disclose material facts (such as loss ratios, denial rates, actual hospital and related charges and exclusions and limitations) to a prospective buyer because the disclosure of these material facts might have influenced the buyer not to enter into the transaction.

Violation 3: Each and every of the aforementioned violations and the cumulative effect thereof is a violation of Regulation XV.C.



ELIGIBILITY

To Apply
Is Now Available To

Gertie Kertus

in ELIGIBILITY NO.: 13024895

The Union Fidelity
$150,000.00
CANCER PLAN

Provides benefits for Cancer treatment in addition to any Group Insurance Plan or Medicare — benefits are payable in cash direct to:

Gertie Kertus

Coverage under this plan is guaranteed to you and members of your family who have not had Cancer. Details of the Plan are given inside.

Henry T. [illegible]
Chairman of the Board

APPLY BY
APRIL 30, 1978
and get FREE . . .
YOUR CANCER
FACT PACK

DETACH ALONG BROKEN LINE

ACT NOW!
SEND NO MONEY

HERE'S HOW TO APPLY

WE'VE ALL BEEN GIVEN FAIR WARNING

Application Form Eligibility No: 13024895

CHECK AMOUNT AND PLAN DESIRED

AMOUNT ☐$150,000 ☐$100,000

PLAN ☐INDIVIDUAL ☐FULL FAMILY

APPLICATION FOR:
UNION FIDELITY LIFE INSURANCE COMPANY 145969-3
TREVOSE, PENNSYLVANIA

(Please Print)

NAME Gertie Kertus

ADDRESS Route 1 Box 295

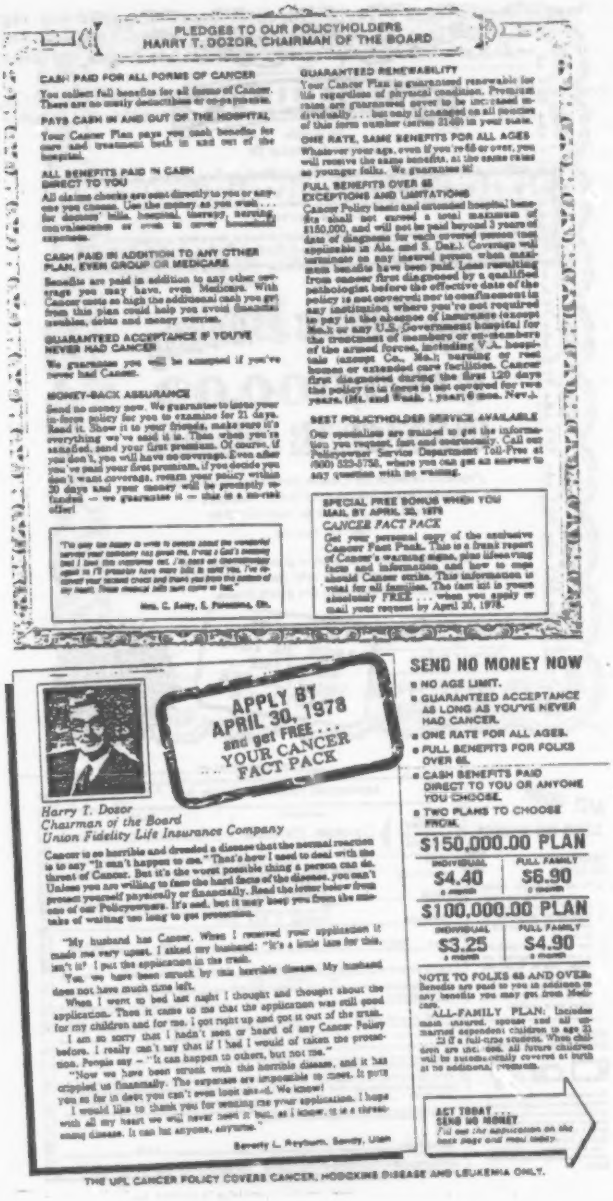
CITY Benton City STATE WA ZIP 99320

DATE OF BIRTH Aug. 26, 1899 AGE 78 Sex Male☐ Female☑

NAME (PLEASE PRINT)	RELATIONSHIP	SEX	DATE OF BIRTH MONTH	DAY	YEAR	AGE
1.						
2.						
3.						

REPRESENTATION & AGREEMENT OF POLICYHOLDER:

SIGNATURE ______ DATE ______



PLEDGES TO OUR POLICYHOLDERS
HARRY T. DOZOR, CHAIRMAN OF THE BOARD

CASH PAID FOR ALL FORMS OF CANCER

You collect full benefits for all forms of Cancer. There are no costly deductibles or co-payments.

PAYS CASH IN AND OUT OF THE HOSPITAL

Your Cancer Plan pays you cash benefits for care and treatment both in and out of the hospital.

ALL BENEFITS PAID IN CASH DIRECT TO YOU

All claims checks are sent directly to you or anyone you choose. Use the money as you wish . . . for doctors' bills, hospital, therapy, nursing, convalescence or even to cover household expenses.

CASH PAID IN ADDITION TO ANY OTHER PLAN, EVEN GROUP OR MEDICARE

Benefits are paid in addition to any other coverage you may have, even Medicare. With Cancer costs so high the additional cash you get from this plan could help you avoid financial troubles, debts and money worries.

GUARANTEED ACCEPTANCE IF YOU'VE NEVER HAD CANCER

We guarantee you will be accepted if you've never had Cancer.

MONEY-BACK ASSURANCE

Send no money now. We guarantee to issue your in-force policy for you to examine for 21 days. Read it. Show it to your friends, make sure it's everything we've said it is. Then when you're satisfied, send your first premium. Of course, if you don't, you will have no coverage. Even after you've paid your first premium, if you decide you don't want coverage, return your policy within 30 days and your money will be promptly refunded — we guarantee it — this is a no-risk offer!

"The only one [illegible] to write to [illegible] about the wonderful service your company has given me. It was a God's blessing that I saw this [illegible]. I'm [illegible] again as I'll [illegible] have more bills to send you. I've received your second check and thank you from the bottom of my heart. These medical bills [illegible]."

Mrs. C. [illegible], S. [illegible], [illegible]

GUARANTEED RENEWABILITY

Your Cancer Plan is guaranteed renewable for life regardless of physical condition. Premium rates are guaranteed never to be increased individually . . . but only if changed on all policies of this form number (series 2140) in your state.

ONE RATE, SAME BENEFITS FOR ALL AGES

Whatever your age, even if you're 65 or over, you will receive the same benefits, at the same rates as younger folks. We guarantee it!

FULL BENEFITS OVER 65
EXCEPTIONS AND LIMITATIONS

Cancer Policy basic and extended hospital benefits shall not exceed a total maximum of $150,000, and will not be paid beyond 3 years of date of diagnosis for each covered person (not applicable in Ala. and S. Dak.). Coverage will terminate on any insured person when maximum benefits have been paid. Loss resulting from cancer first diagnosed by a qualified pathologist before the effective date of the policy is not covered; nor is confinement in any institution where you're not required to pay in the absence of insurance (except Md.) or any U.S. Government hospital for the treatment of members or ex-members of the armed forces, including V.A. hospitals (except Co., Md.); nursing or rest homes or extended care facilities. Cancer first diagnosed during the first 120 days the policy is in force is not covered for two years. (Ill. and Wash. 1 year; 6 mos. Nev.).

BEST POLICYHOLDER SERVICE AVAILABLE

Our specialists are trained to get the information you request, fast and courteously. Call our Policyowner Service Department Toll-Free at (800) 523-5758, where you can get an answer to any question with no waiting.

SPECIAL FREE BONUS WHEN YOU MAIL BY APRIL 30, 1978

CANCER FACT PACK

Get your personal copy of the exclusive Cancer Fact Pack. This is a frank report of Cancer's warning signs, plus lifesaving facts and information and how to cope should Cancer strike. This information is vital for all families. The fact kit is yours absolutely FREE . . . when you apply or mail your request by April 30, 1978.

APPLY BY
APRIL 30, 1978
and get FREE . . .
. . . YOUR CANCER
FACT PACK

Harry T. Dozor
Chairman of the Board
Union Fidelity Life Insurance Company

Cancer is so horrible and dreaded a disease that the normal reaction is to say "It can't happen to me." That's how I used to deal with the threat of Cancer. But it's the worst possible thing a person can do. Unless you are willing to face the hard facts of the disease, you can't protect yourself physically or financially. Read the letter below from one of our Policyowners. It's sad, but it may keep you from the mistake of waiting too long to get protection.

"My husband has Cancer. When I received your application it made me very upset. I asked my husband: "It's a little late for this, isn't it?" I put the application in the trash.

Yes, we have been struck by this horrible disease. My husband does not have much time left.

When I went to bed last night I thought and thought about the application. Then it came to me that the application was still good for my children and for me. I got right up and got it out of the trash.

I am so sorry that I hadn't seen or heard of any Cancer Policy before. I really can't say that if I had I would of taken the protection. People say — "It can happen to others, but not me."

"Now we have been struck with this horrible disease, and it has crippled us financially. The expenses are impossible to meet. It puts you so far in debt you can't even look ahead. We know!

I would like to thank you for sending me your application. I hope with all my heart we will never need it but, as I know, it is a threatening disease. It can hit anyone, anytime."

Beverly L. Rayburn, Sandy, Utah

SEND NO MONEY NOW

- NO AGE LIMIT.
- GUARANTEED ACCEPTANCE AS LONG AS YOU'VE NEVER HAD CANCER.
- ONE RATE FOR ALL AGES.
- FULL BENEFITS FOR FOLKS OVER 65.
- CASH BENEFITS PAID DIRECT TO YOU OR ANYONE YOU CHOOSE.
- TWO PLANS TO CHOOSE FROM.

$150,000.00 PLAN	
INDIVIDUAL	FULL FAMILY
$4.40 a month	$6.90 a month

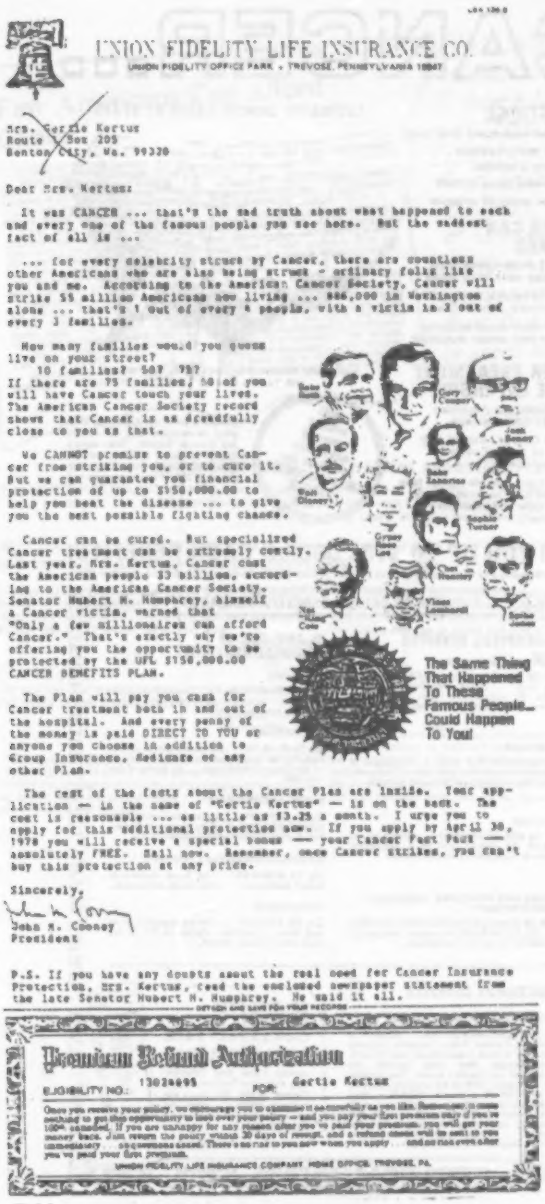
$100,000.00 PLAN	
INDIVIDUAL	FULL FAMILY
$3.25 a month	$4.90 a month

NOTE TO FOLKS 65 AND OVER: Benefits are paid to you in addition to any benefits you may get from Medicare.

ALL-FAMILY PLAN: Includes main insured, spouse and all unmarried dependent children to age 21 (23 if a full-time student). When children are included, all future children will be automatically covered at birth at no additional premium.

ACT TODAY . . .
SEND NO MONEY
Fill out the application on the back page and mail today.

THE UFL CANCER POLICY COVERS CANCER, HODGKINS DISEASE AND LEUKEMIA ONLY.


Babe Ruth
Gary Cooper
Jack Benny
Babe Zaharias
Walt Disney
Sophie Tucker
Gypsy Rose Lee
Chet Huntley
Nat "King" Cole
Vince Lombardi
Spike Jones
The Same Thing That Happened To These Famous People... Could Happen To You!

UNION FIDELITY LIFE INSURANCE CO.
UNION FIDELITY OFFICE PARK • TREVOSE, PENNSYLVANIA 19047

Mrs. Gertie Kertus
Route 1 Box 205
Benton City, Wa. 99320

Dear Mrs. Kertus:

It was CANCER ... that's the sad truth about what happened to each and every one of the famous people you see here. But the saddest fact of all is ...

... for every celebrity struck by Cancer, there are countless other Americans who are also being struck - ordinary folks like you and me. According to the American Cancer Society, Cancer will strike 55 million Americans now living ... 886,000 in Washington alone ... that's 1 out of every 4 people, with a victim in 2 out of every 3 families.

How many families would you guess live on your street?
10 families? 50? 75?
If there are 75 families, 50 of you will have Cancer touch your lives. The American Cancer Society record shows that Cancer is as dreadfully close to you as that.

We CANNOT promise to prevent Cancer from striking you, or to cure it. But we can guarantee you financial protection of up to $150,000.00 to help you beat the disease ... to give you the best possible fighting chance.

Cancer can be cured. But specialized Cancer treatment can be extremely costly. Last year, Mrs. Kertus, Cancer cost the American people 33 billion, according to the American Cancer Society. Senator Hubert H. Humphrey, himself a Cancer victim, warned that "Only a few millionaires can afford Cancer." That's exactly why we're offering you the opportunity to be protected by the UFL $150,000.00 CANCER BENEFITS PLAN.

The Plan will pay you cash for Cancer treatment both in and out of the hospital. And every penny of the money is paid DIRECT TO YOU or anyone you choose in addition to Group Insurance, Medicare or any other Plan.

The rest of the facts about the Cancer Plan are inside. Your application — in the name of "Gertie Kertus" — is on the back. The cost is reasonable ... as little as $3.25 a month. I urge you to apply for this additional protection now. If you apply by April 30, 1978 you will receive a special bonus — your Cancer Fact Pact — absolutely FREE. Mail now. Remember, once Cancer strikes, you can't buy this protection at any price.

Sincerely,

John H. Cooney
President

P.S. If you have any doubts about the real need for Cancer Insurance Protection, Mrs. Kertus, read the enclosed newspaper statement from the late Senator Hubert H. Humphrey. He said it all.

DETACH AND SAVE FOR YOUR RECORDS

Premium Refund Authorization

ELIGIBILITY NO.: 13024695 FOR: Gertie Kertus

Once you receive your policy, we encourage you to examine it as carefully as you like. Remember, it costs nothing to get this opportunity to look over your policy — and you pay your first premium only if you're 100% satisfied. If you are unhappy for any reason after you've paid your premium, you will get your money back. Just return the policy within 30 days of receipt, and a refund check will be sent to you immediately . . . no questions asked. There's no risk to you now when you apply . . . and no risk even after you've paid your first premium.

UNION FIDELITY LIFE INSURANCE COMPANY, HOME OFFICE, TREVOSE, PA.

CANCER...

WILL STRIKE

- 55 million Americans alive today
- 1 out of every 4 people
- 2 of every 3 families
- 700,000 new cases in 1978
- One case every 45 seconds

CANCER CAN BE CURED

- Almost 2 million Americans alive today have been cured
- 233,000 more will be cured this year 1/3 of all new Cancer Cases
- 117,000 more could be saved this year with earlier treatment

CANCER TREATMENT CAN BE EXPENSIVE

- Cancer costs the American People $3 Billion a year
- Average Cancer hospital stay is twice as long as other hospitalization
- Cancer costs include higher fees for physicians' services, drugs, nursing care and sick-room equipment

ESTIMATED CANCER CASES BY STATE

How Many Victims Will There Be In Your State? Will You Be One Of Them?

Help protect yourself and family now with the UFL $150,000.00 CANCER PLAN

Statistics from the American Hospital Association and the American Cancer Society. Your state's Cancer estimate is based on the American Cancer Society's prediction that 25% of all Americans will get cancer.

PAYS YOU UP TO $150,000.00 CASH BENEFITS!

All Cancer Benefits Are Paid In Cash Direct To You, In Addition To Medicare, Group Or Any Other Plan.

$150,000.00 CANCER BENEFITS SUMMARY

IN-HOSPITAL BENEFITS

HOSPITAL CONFINEMENT:
$60.00 Per Day . . . for the first 7 consecutive days . . . $50.00 Per Day thereafter. (After 90 consecutive days of hospitalization, see Extended Hospital Benefits.)

PHYSICIAN:
Up to $15.00 Per day . . . Maximum of $900.00 for care by a physician or surgeon, other than surgeon performing surgery

NURSING:
Up To $36.00 Per Day . . . Maximum of $900.00 for special care by a Registered Nurse or Licensed Practical Nurse.

DRUGS AND MEDICINES, INCLUDING CHEMOTHERAPY:
5% Of Hospital Confinement Benefits . . . Up To $375.00 for actual charges incurred for drugs and medicines.

IN-AND-OUT OF HOSPITAL BENEFITS

SURGICAL:
$45.00 To $750.00 Per Operation . . . no limit on number, according to policy surgical schedule.

ANESTHESIA:
Up To $185.00 . . . for each internal operation; $45 for each Cancer operation. No limit on number of operations . . . in or out of the hospital.

BLOOD AND PLASMA:
Up To $450.00 . . . for charges incurred for blood and plasma . . . even as an outpatient. No maximum on benefits for leukemia.

X-RAY-RADIUM-COBALT THERAPY:
Up To $1000.00 . . . for X-ray, radium or cobalt treatment . . . even as an outpatient.

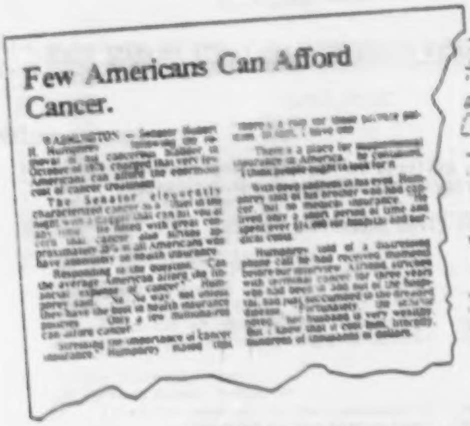
AMBULANCE:
Up To $750.00 . . . for transportation to and from a hospital, limited to $75.00 for each confinement period.

ADDITIONAL BENEFITS

EXTENDED HOSPITAL BENEFITS:
Up To $7,500.00 A Month . . . $250.00 A Day . . . Cancer Policy benefits increase after you've been hospitalized past 90 days. Even though your basic benefits are exhausted, you needn't worry. This is when you'll be paid 100% of all hospital charges, up to $7,500.00 a month ($250.00 a day). These are in addition to benefits you've already received. Benefits will be paid continuously until you're discharged from the hospital . . . or until you've collected a lifetime maximum of $150,000.00.

SPECIAL FREE BONUS . . .
CANCER FACT PACK
A Frank Report On Cancer's Warning Signs, Plus Life-saving Facts And Information And How To Cope Should Cancer Strike. It's yours absolutely FREE . . . when you apply or mail your request by April 30, 1978.

AN OPTIONAL $100,000 PLAN IS ALSO AVAILABLE . . . AT REDUCED RATES, WITH BENEFITS 2/3 OF THE $150,000 PLAN ABOVE.



Few Americans Can Afford Cancer.

The late Hubert H. Humphrey, a former U.S. Senator and Presidential Candidate, knew first hand about the high cost of cancer treatment. In this exclusive Newspaper interview prior to his death, he urged every American to seek Cancer insurance coverage.

BUT CANCER DOESN'T ONLY STRIKE PROMINENT PEOPLE LIKE HHH

IT ALSO STRIKES FOLKS LIKE YOU, folks who might not be able to afford the ". . . enormous cost of cancer treatment . . .", as Senator Humphrey noted. The American Cancer Society estimates that 55 million Americans living today will become victims of that dread disease.

BUT YOU DON'T HAVE TO STAND ALONE IN THE FIGHT AGAINST CANCER . . . Here are letters from just a few of our grateful policyholders:

"I am writing to tell you how thankful I am to receive benefits payment on the cancer policy. You can believe that I am telling all my friends about your company. The benefits have sure lightened our expense load so that we can see our way clear."

Clarence West
Zephyrhills, Fl.

"My coverage was very helpful to me and I was well pleased with your service. I intend to recommend your company to my friends."

Beatrice Pursley
Barberton, Oh.

"The coverage provided by my Union Fidelity Insurance Policy was a great help to me in paying for the Cancer surgery. I have recommended the coverage to others and I carry a Union Fidelity policy on my mother, which also proved helpful. . . . The payment was made, and I was very glad to get it."

Beverly Harris Grey
San Juan Capistrano, Ca.

". . . I wish to thank your company for the promptness in paying all the claims on my husband's illness. I don't know what we would have done without your policy. If only more people would realize how quickly they can be struck with cancer, they would buy your policy."

Mrs. Marie Peabody
Houston, Tx.

"Just a note to thank you for your promptness in settling our claims on the two policies we have with you people. It just goes to prove that you can't find a better company to do business with. We are lucky to have had the foresight to take these policies out when we did. It makes one's recovery easier to know that you can pay the doctors' bills promptly when they are so responsible for your life."

Mrs. Moore
Minneapolis, Mn.

EXHIBIT 3

CANCER EXTRAS RIDER and CANCER INCREASE RIDER

Contents   Page No.

I. Review of Brochures Utilized in the Marketing and Promotion of UFLIC Cancer Extras Rules and Cancer Increase Rider. 1

II. Analysis of Benefits (From Underlying Policy) 1

III. Legal Anaylsis. 3-33

EXHIBIT 3

I. Review of Brochures Utilized in the Marketing and Promotion of UFLIC Cancer Extras Rules and Cancer Increase Rider

Subject Matter

A. Items Reviewed

1. Cancer "Extras" Promotional Brochure
   UFLIC Form Number B-82-B (sold with base policy $150,000)
2. Cancer Increase Rider
   UFLIC Form Number B-64-42 (sold with base policy $150,000)

B. Underlying Insurance Policy Form

1. Cancer Extras Rider
   UFLIC Form Number 1-4540-2
   Filed for approval in the Commonwealth: December 30, 1975
   Approved by the Commissioner: December 31, 1975

2. Cancer Increase Rider
   UFLIC Form Number 1-4930-99
   Filed for approval in the Commonwealth: November 9, 1977
   Approved by the Commissioner: November 10, 1977

C. Segment of Population to Which Materials are Directed

All cancer benefits policy holders.

D. Loss Ratios From Sample

1. Cancer Extras - 3.4%
2. Cancer Increase - 24.6% (same as base policy 2140)

II. Analysis of Benefits (From Underlying Policy)

A. Cancer Extras Rider

1. After-Hospital Benefits:

After discharge from a qualified hospital in which covered person was a resident patient, 10% of the total in-patient hospital benefits will be paid.

Maximum Benefits: $15,000

2. Intensive Care Unit Benefits:

Double the daily hospital benefit paid when covered person is confined to a special unit of a hospital specifically providing intensive care for the treatment of cancer to a maximum of

21 days. Periods of post-operative confinement in a recovery room of less than 24 hours are not covered. Policy does not specify if daily rates are based upon first confined or last confined days.

Maximum Benefits: $ 2,940

3. Skilled Nursing Facility Benefit:

If physician determines that skilled nursing care or skilled rehabilitative services of a skilled nursing facility is needed for further treatment of cancer after the patient has been hospitalized for at least 3 consecutive days, 50% of the daily hospital benefits will be paid up to a maximum of 60 days. Policy does not specify if in-hospital benefits are based upon first or last hospital days. Admission to the skilled nursing facility must be within 14 days of discharge from the hospital. Skilled nursing facility does not include rest homes or homes for the aged which provide primarily custodial care. To be covered a daily medical record must be kept of each patient and such patient shall receive a planned program of observation by a physician other than the proprietor or an employee of such nursing facility. Such plan must be in accordance with existing standards of medical practice for the injury or sickness causing confinement; in this case it must be cancer.

Maximum Benefits: $ 1,905

4. Pre-Existing Condition:

Cancer first manifested prior to the effective date of the rider is not covered for 1 year from date of rider. Manifested is a different standard than diagnosed.

B. Cancer Increase Rider (From Underlying Policy)

All benefits are increased by 33 1/3%. All definitions of base policy remain in force.

1. Hospital Confinement:

1-7 days -- $120/day = $840
8-90 days -- $ 80/day = $6,640

Maximum Benefits: $ 7,480

2. Physician:

Actual charges to $20/day Maximum Benefits: $ 1,200

3. Surgical:

$60 - $1,000 Maximum Benefits $ 1,000

4. Nursing:	Maximum Benefits:	$ 1,200
5. X-Ray - Radium - Cobalt	Maximum Benefits:	$ 2,000
6. Anesthesia:	Maximum Benefits:	$ 140
7. Blood and Plasma:	Maximum Benefits:	$ 600
8. Ambulance:	Maximum Benefits:	$ 1,000
9. Drugs and Medicine:	Maximum Benefits:	$ 500
	Total Extended Benefits:	$15,120
	Remaining Benefits:	$184,880

10. Extended Hospital Benefits (to a maximum of 33 months)

    $333.33/day or $10,000/month (1005 days)

    If actual charges are less than $183.96/day, benefits cannot be collected to policy maximum. The promotional brochure with this policy cites $158 per day as the average.

III. Legal Analysis

A. Purpose

In general it is deemed to be misleading to solicit an offer to contract for health insurance without a clear and conspicuous disclosure of the following:

1. The extent and nature of the coverage offered.
2. The extent to which the coverage meets the potential risk.
3. The cost of the coverage.

All marketing methods and practices pertaining to the sale of health insurance are subject to the minimum standards and guidelines of conduct established by the rules and regulations promulgated pursuant to Massachusetts General Laws Chapters 175, 176D and 93A, among others. These regulations and rules are intended to assure truthful and adequate disclosure of all material and relevant information in the advertising and marketing of this insurance. All information required to be disclosed by these rules shall be presented conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or disclosed in any manner so as to be confusing or misleading.

B. Regulations 1-74

1. Rules Pertaining to Form and Content of Advertisements (Section 5 A. & B)

   "A. The format and content of an advertisement of an accident or sickness insurance policy shall "be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

"B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used."

a. Cancer Extras Rider:

Violation 1: The format of the advertisement emphasizes the extra benefits to be received and gives these benefits in dollar amounts. The format and content is misleading and incomplete because it fails to include definitions of, restrictions upon and reductions from the benefits. The omitted definitions include those for intensive care units and nursing home facilities. The definition of nursing home, as it is known by a layperson, is substantially different than that of the skilled nursing facility set forth in the policy. The policy thus requires and assumes a knowledge of insurance terminology.

Violation 2: The benefits are set forth in a manner which has the tendency to mislead the policy holder about the probability of collecting full benefits. The probability of collecting full benefits is slight.

Violation 3: All benefits are based upon the in-hospital cash benefits paid. The daily rate for base hospital benefits paid varies depending upon the length of stay. The advertising material makes it appear the base period starts with the first day, yet the policy itself fails to clarify this. The failure to clarify the ambiguity renders the advertisement misleading and gives it the capacity to deceive.

Violation 4: The rider is marketed to policy holders of the cancer benefit policy critiqued in Exhibit B-1. Since this advertisement relies upon and refers to materials or information found in the cancer benefit policy (Form 2140) and since the cancer benefit policy form is in violation of this Section, this cancer extras rider is in violation of this Section to the extent that the cancer benefit policy violates this Section.

Violation 5: The textual material following the italicized words "It's Cancer" is incomplete to the extent that it omits relevant information as to the probability and costs of cancer. This omission exaggerates the dangers of cancer and thus has the capacity to mislead the policy holder as to the need for the rider.

Violation 6: The statement under the after-hospital cash section, that the exact amount depends on you and you alone, has the tendency to mislead the policy holder because many factors outside the control of the policy holder will contribute to the actual benefits paid.

Violation 7: The recitation of benefits is incomplete because it fails to set forth expected actual costs against which the policy holder can compare benefits to determine if in fact the benefits will provide the "extra protection" which the rider seems to offer.

Violation 8: The statement that the policy rider can never be cancelled as long as premiums are paid and the base policy remains in force is misleading because it fails to disclose adequately that the rider will terminate three years from the date on which cancer is diagnosed.

Violation 9: The exclusion of cancer first manifested prior to the effective date of the rider is misleading and deceptive because it creates a different standard from that of the base policy which relies upon the date of diagnosis of cancer for determining exclusion.

Violation 10: There is no definition of pre-existing condition. The omission of this definition is misleading and has the tendency to deceive the policy holder.

Violation 11: The use of the cited testimonial letter is misleading and deceptive. First, the letter appears to be unsolicited when in fact some of them were solicited. Second, some of the statements have been altered or taken out of context so as to change the meaning. For instance, one letter omits a paragraph which is critical of the company for its slow claims payment. Finally, not all of the persons quoted are persons covered by the cancer extras rider.

Violation 12: The practice of sending out a premium notice including the premium for the base policy together with that for the "cancer extras rider" is misleading and has the capacity of inducing the policy holder to pay for a rider inadvertently while attempting to keep his or her base policy in force.

Violation 13: The statement "you'll collect" is misleading and deceptive because the amount promised by the rider will only be paid if the actual charges incurred by the policy holder are greater than or equal to the combined benefits of the basic policy and this rider. Otherwise, the benefits offered by the rider are superfluous.

b. Cancer Increase Rider:

Violation 1: The designation of this rider as a cancer increase rider and the inclusion of statements such as each and every cancer benefit increased by 33 1/3% has the tendency to mislead and deceive. First, it is virtually impossible to collect the maximum benefits available under the base policy. To increase benefits by any amount without increasing the underlying probability that the benefits will be

Violation 8: The recitation of nursing benefits has the capacity to mislead and it is not sufficiently clear and complete to avoid deception. First, it is unclear if the benefits are for actual charges or for a flat sum. Second, it fails to include or refer to the restrictive definition of in-hospital nursing services found in the policy. The reference to lifetime benefits is also misleading.

Violation 9: The reference to other cancer riders offered by the company has the capacity to mislead because it fails to specify the benefits offered by such other plans and to provide the policy holder with sufficient information to evaluate what, if any, duplication or overlap of coverage may result from the acquisition of the cancer increase rider.

Violation 10: The recitation of X-ray/radiation/cobalt therapy benefits is not sufficiently clear and complete to avoid deception because it fails to set forth the exclusions (other than diagnostic X-ray) of diagnostic procedures or laboratory tests related to this treatment.

Violation 11: The recitation of the anesthesia benefits is deceptive and incomplete because it fails to state that the anesthesia will not be covered if the anesthesiologist is employed by the hospital.

Violation 12: The recitation of blood and plasma benefits is not sufficiently clear to avoid deception because it fails to include references to any credits the policy holder may receive for blood replaced by donors. Furthermore, the reference to lifetime benefits is misleading as is the statement that there is no maximum on leukemia. All benefits to be collected must be directly related to the treatment of cancer. Consequently, they are all subject to the three-year limitation of the policy.

Violation 13: The recitation of ambulance benefits is deceptive and not sufficiently clear and complete to avoid misleading the policy holder. The reference to lifetime benefits is deceptive. The failure to include or refer to the definition of the hospital confinement period or the requirement of admission to the hospital has the tendency to mislead.

Violation 14: The recitation of extended hospital benefits is not sufficiently clear to avoid deception and it has the capacity and tendency to mislead and deceive. First, it is not sufficiently clear that only actual charges are to be collected. Second, the advertisement itself cites a figure of $158 per day as the average daily charge. If this is true, it will take over three years to collect the maximum benefits. As this is beyond the policy limit, full coverage literally cannot be collected.

Violation 15: The statement of limitations and exclusions is incomplete and unclear. It fails to include many restrictive definitions found in the underlying policy. The repeated reference to "lifetime" benefits is misleading because there is actually a three-year limit on benefits. It also fails to include a clear statement that benefits are not provided for any other disease, sickness or incapacity even though such disease or incapacity may have been complicated or aggravated or prolonged by such covered cancer or be as a result of covered cancer treatment.

Violation 16: The format of the entire brochure is not sufficiently clear and complete to avoid deception or misunderstanding because it fails to include any reliable estimated figures as to actual costs which may be incurred by the policy holder, which figure or cost could be utilized in analyzing and evaluating the additional coverage offered by this rider.

Violation 17: The reference to Union Fidelity as one of America's largest cancer insurance specialists and to Mr. Dozer as an insurance expert has the tendency to mislead the policy holder because it fails to set forth the facts or experience upon which such claim of expertise are based. Such statements require a familiarity with the insurance industry which the typical policy holder lacks.

Violation 18: The practice of sending a premium notice which includes the premium charge for the rider being promoted has the capacity to mislead because it may induce the policy holder to pay for a rider inadvertently while meaning only to keep his or her base policy in force.

Violation 19: To the extent the policy holder is induced to purchase the rider by reference to statements or information contained in materials related to the basic Cancer Benefits Policy (Form 2140) and to the extent such material or information from the cancer benefits policy is in violation of this Section 5, this cancer increase brochure is in violation of Section 5.

2. Rules Pertaining to Advertisements of Benefits Payable, Losses Covered or Premiums Payable (Section 6A. (1)-(8))

"A. Deceptive Words, Phrases or Illustrations Prohibited

"(1) No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective. purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

"(2) No advertisement shall contain or use words or phrases such as 'all'' 'full'; 'complete';

"'comprehensive'; 'unlimited'; 'up to'; 'as high as'; 'this policy will help fill some of the gaps that Medicare and your present insurance leave out'; 'this policy will help to replace your income' (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

"(3) An advertisement shall not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as, describing a waiting period as a 'benefit builder', or stating 'even pre-existing conditions are covered after two years.' Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

"(4) No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as 'tax free'; 'extra cash'; 'extra income'; 'extra pay'; or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

"(5) No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

"(6) No advertisement of a policy covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

> "(7) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automboile accidents, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following: 'THIS IS A LIMITED POLICY'; 'THIS IS A CANCER ONLY POLICY'; 'THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY'.
>
> "(8) An advertisement of a direct response insurance product shall not imply that because 'no insurance agent will call and no commissions will be paid to agents' that it is 'a low cost plan,' or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product."

a. Cancer Extras Rider

Violation 1: The brochure omits information concerning actual costs and courses of treatment associated with cancer and thereby misleads the policy holder as to the nature and extent of policy benefits payable and losses covered. It also fails to include restrictive definitions, exclusions and reductions and therefore exaggerates the benefits beyond the terms of the policy.

Violation 2: The statement that "there are no reductions in benefits for people over 65...ever" is misleading to prospective purchasers because it omits reference to conditions under which the policy may terminate and exaggerates the benefits beyond the terms of the policy.

Violation 3: The reference to possible courses of treatment upon which a doctor may insist has the effect of misleading or deceiving the policy holder as to the probability of such medical requirements and as to the benefits payable and losses covered under the policy.

Violation 4: The statement that the after-hospital cash benefits payable depends upon the policy holder has the effect of misleading the policy holder because it omits reference to other factors affecting the collection of these benefits and thereby exaggerates the benefits payable under the policy.

Violation 5: The statement "of course, after two years, pre-existing conditions will be covered" is an expression of a limitation of the policy worded in a positive manner. Such limitation must fairly and accurately set forth the negative features of such limitation.

Violation 6: Statements such as "all cash paid direct to you" and "pays you cash" exaggerate the coverage provided by the policy and have the capacity or effect of misleading the public into believing the coverage will enable them to make a profit from being hospitalized.

Violation 7: The omission of a clear and conspicuous statement in prominent type that the policy is limited to cancer only and does not cover some expenses of cancer treatment or cancer related treatments is a violation of Subsection 7 and it has the effect or tendency of exaggerating the coverage afforded by the policy.

Violation 8: The recitation of nursing home benefits implies coverage beyond the terms of the policy because the definition of nursing home in the policy is more restrictive than commonly understood by the general public.

Violation 9: The statement that "Preferred Cancer Policyholder can expand their coverage" tends to deceive the prospective purchaser as to the nature of the benefits which the policy offers because it implies that such policy holder has to be singled out when in fact such is not the case. The rider is marketed to substantially all cancer policy holders without preference.

Violation 10: The statement that payments will be made regardless of other insurance plans omits reference to coordination of benefits provided in such other plans and therefore exaggerates the coverage and benefits available under the policy.

Violation 11: The statement that the cancer extras rider may make the difference in the event "cancer strikes and the 'policy holder's' life hangs in the balance" exaggerates the benefits payable under the policy and is otherwise misleading.

b. Cancer Increase Rider

Violation 1: The emphasis on the benefit increase of 33 1/3% and on the maximum benefits payable has the capacity and tendency to deceive and mislead a prospective purchaser as to the extent of the policy benefits payable or the increase offered and tends to exaggerate the likely benefits payable beyond the terms of the policy. Such statements tend to exaggerate the utility of the underlying policy (Form 2140) and the proffered cancer increase rider.

Violation 2: The term "up to 3 years" as it pertains to the limitation of coverage is a description of a limitation in a positive manner. It is a contradiction in terms to state a lifetime maximum up to 3 years. All references to lifetime benefits therefore exaggerate the terms of the policy.

Violation 3: The omission of a clear and conspicuous statement in prominent type that the benefits are payable only for those expenses which are directly related to cancer and that the policy does not cover some expenses of cancer treatment or related treatments is misleading and tends to deceive the policy holder.

best copy available

Violation 4: The offering of the rider to "preferred" cancer policy holders only is deceptive and misleading because it tends to exaggerate the benefits payable or the value of the policy. The cancer increase rider is offered to substantially all cancer policy holders and there is no selection process by which preferred policy holders would be segregated.

Violation 5: The recitation of the Cancer Benefits Policy benefits and the statement that substantial cash benefits would be received up to a maximum of $150,000 tends to exaggerate the benefits available and the losses covered under the policy because it is highly unlikely benefits to such extent would be received.

Violation 6: The statement that "for pennies a day per person every single cancer benefit can be increased by 33 1/3%" exaggerate the extent of increase, the losses covered and the premium payable because it omits pertinent restrictions and limitations on the collection of those benefits. First, all benefits are not increased because many benefits are based upon actual expenses which remain the same in spite of the increased coverage. Second, the reference to pennies per day per person without reference to the actual premium payable exaggerates the nature and extent of the premium.

Violation 7: The claim that the real need for the increase is based upon inflation and in response to requests by cancer policy holders tends to exaggerate the nature and extent of the benefits payable because relevant factual information or actual increases in cost is omitted.

Violation 8: The recitation of policy benefits commencing with the words "PAY YOU" tends to exaggerate the benefits beyond the terms of the policy because the policy is an indemnity policy paying only actual expenses in most cases.

Violation 9: Statements concerning "substantial cash benefits" when read in conjunction with guarantees of increases of 33 1/3% have the capacity and tendency to mislead the public into believing that the policy will enable them to make a profit from being hospitalized. For instance, the advertisement cites the average daily hospital bill of $150 per day and promises up to $333.33 per day for extended hospital benefits.

Violation 10: The exceptions and limitations provision omits substantive limitations in the policy, including definitions and limitations to actual charges incurred. (See policy benefits analysis.) Consequently, all limitations, exceptions and reductions are not fairly and accurately described.

Violation 11: The statement that "benefits will be paid until discharge from the hospital" is misleading and deceptive because it fails or omits to disclose that coverage is provided for multiple or successive periods of confinement.

Violation 12: To the extent the advertisement incorporates or refers to provisions of the underlying cancer benefit policy, which provisions are in violation of this Section 6, the advertisement is in violation of Section 6.

3. Rules Pertaining to Exceptions, Reductions and Limitations (Section 6B. (1)-(3)) and Pre-Existing Conditions (Section 6C. (1)-(3))

"B. Exceptions, Reductions and Limitations

"(1) When an advertisement refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

"(2) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

"(3) An advertisement shall not use the words 'only'; 'just'; 'merely'; 'minimum' or similar words or phrases to describe the applicability of any exceptions and reductions, such as: 'This policy is subject to the following minimum exceptions and reductions.'

"C. Pre-Existing Conditions

"(1) An advertisement which is subject to the requirements of Section 6B shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The use of the term 'pre-existing condition' without an appropriate definition or description shall not be used.

"(2) When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the "policy or payment of a claim thereunder. This rule prohibits the use of the phrase 'no medical examination required' and phrases of similar import, but does not prohibit explaining 'automatic issue.' If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required.

"(3) When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question or statement which reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question or statement substantially as follows:

> "Do you understand that this policy will not pay benefits during the first __year(s) after the issue date for a disease or physical condition which you now have or have had in the past? YES

"Or substantially the following statement:

> "I understand that the policy applied for will not pay benefits for any loss incurred during the first ___ year(s) after the issue date on account of disease or physical condition which I now have or have had in the past."

a. Cancer Extras Rider

Violation 1: The advertisement fails to include all substantive exceptions, restrictions and limitations affecting the benefits payable under the policy thus giving the advertisement the capacity to mislead. This is primarily true of restrictive definitions of losses covered by the policy.

Violation 2: Reference to "pre-existing conditions" without an appropriate definition or description thereof is misleading and has the tendency to deceive.

Violation 3: The instructions as to how to apply for the cancer extras rider without a clear explanation of pre-existing conditions provision implies that the applicant's physical condition will not affect the issuance of the policy.

b. Cancer Increase Rider

Violation 1: The advertisement refers to the low cost of the rider and the benefits offered therein without adequately disclosing exceptions, limitations and reductions. The omission gives the policy the tendency to mislead.

Violation 2: The advertisement minimizes the effect of the exclusions and limitations applicable by attempting to incorporate by reference those of the base cancer policy without a full explanation thereof.

Violation 3: The application, which is part of the advertisement, fails to include an adequate question or statement reflecting the pre-existing conditions provisions of the policy. The statement on the application, to be signed by the main insured and which inquires as to the existence of cancer, is not sufficient when viewed in relation to the fact that the policy is marketed to "preferred" policy holders thus implying that acceptance is a mere formality.

Violation 4: To the extent this advertisement builds upon and incorporates or relies upon information pertaining to the base policy (Form 2140), which base policy is in violation of this Section, this material is in violation of this Section.

4. Rules Pertaining to Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination (Section 7)

> "When an advertisement refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit; or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions."

a. Cancer Extras Rider

Violation 1: The advertisement does not sufficiently and clearly disclose provisions relating to termination and renewability of coverage and thereby minimizes or obscures these provisions. Statements that the policy can never be cancelled and references to maximum benefits payable overstate the availability of such benefits because all benefits terminate three years from the date of diagnosis of cancer.

b. Cancer Increase Rider

Violation 1: The advertisement does not clearly and sufficiently disclose restrictions on the payments of benefits and renewability of the policy. Continued references to lifetime maximum and the gross amount of benefits payable are inconsistent with, overshadow and thereby minimize and obscure the one statement regarding the three-year limitation of policy coverage. In effect, what the policy offers is lifetime renewability as long as claims are not submitted for cancer. Once cancer is diagnosed, the policy becomes a three-year policy.

5. Rules Pertaining to Testimonials or Endorsements by Third Parties (Section 8A. and B.)

> "A. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement is subject to all the provisions of these rules.
>
> "B. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: 'Paid Endorsement.' This rule does not require disclosure of union 'scale' wages required by union rules if the payment is actually for such 'scale' for TV or radio performances. The payment of substantial amounts, directly or indirectly, for 'travel and entertainment' for filming or recording of TV or radio advertisements remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation."

a. Cancer Extras Rider

Violation 1: The testimonials used do not necessarily all refer to the "cancer extras" rider. While all quoted persons are or were policy holders at the time of the endorsement, not all were covered by the cancer extras rider; thus, the use of the testimonial as an aid to the sale of the rider is misleading.

Violation 2: The testimonials are not accurately reproduced and omit certain phrases. An entire paragraph citing unreasonable claims payment delay was omitted from one testimonial. A phrase of similar import was omitted from another testimonial.

Violation 3: Many of the testimonials were solicited by the company and all received the sum of at least $1.00 for the use of their comments. The company states to the author of the testimonial that the payment of such sum is intended to be a "token of company appreciation" when it is, in fact, the payment of consideration to said author for a signed release for the use of the testimonial. Thus, the testimonials are obtained deceptively by the company and then used as unsolicited testimonials at a later date.

6. Rules Pertaining to Use of Statistics (Section 9)

> "A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.
>
> "B. An advertisement shall not represent or imply that claim settlements by the insurer are 'liberal' or 'generous' or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.
>
> "C. The source of any statistics used in an advertisement shall be identified in such advertisement."

a. Cancer Extras Rider

Violation 1: The recitation of hypothetical situations concerning the course of cancer treatment or costs associated therewith is misleading and deceptive and constitutes the use of irrelevant facts in the promotion of the rider. The advertisement implies that the cited expenditures would be covered by the policy.

Violation 2: The statements of benefits commencing with "you'll collect" are misleading and imply an ease in the collection is said benefits which is not consistent with the underlying facts of cancer treatment or with company practices and claim payment history.

b. Cancer Increase Rider

Violation 1: The use of statistics from the American Cancer Society and statements implying that this rider has been developed in response to a popular demand by "millions of Americans" is misleading and deceptive. First, these statements are not facts and second, even as fact they are irrelevant. The statement that the average hospital bill is $158 and that the average cancer hospital stay is double the stay for other hospitalization constitutes the use of irrelevant facts because it does not reveal the components of the average daily hospital bill or the usual length of hospitalization.

Violation 2: The emphasis on the 33 1/3% increase in benefits is misleading and implies claims settlement practices which are beyond the actual terms of the policy. First, many benefits are paid on the basis of actual costs, thus the increase may be irrelevant. Second, the advertisement fails to include actual costs or payments history so that the policy holder can accurately evaluate the utility of the increased benefits.

7. Rules Pertaining to Identification of Plan or Number of Policies (Section 10)

> "A. When a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.
>
> "B. When an advertisement refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies."

a. Cancer Extras Rider

Violation 1: The policy fails to explain or disclose fully the extent to which benefits are paid in addition to the benefits of the base policy or instead of the benefits of the base policy. For instance, intensive care benefits would generally be provided while the patient is in the hospital. Thus, it is unclear whether the policy holder would collect the offered intensive care benefits in addition to the regular hospital benefits or instead of said benefits. The same is true of skilled nursing facilities which in some cases are associated with hospitals or other institutions which may qualify for daily hospital benefits.

b. Cancer Increase Rider

Violation 1: The advertisement fails to disclose the extent to which the rider augments or is a substitute for the benefits mentioned in other cancer riders, such as Cancer Extras, After Hospital, Cancer Intensive Care and Cancer Skilled Nursing. If any of these riders are owned by the policy holder and such other riders actually increase benefits to the extent promised, then the $200,000 maximum limits would not be increased and there would be no additional benefits or coverages afforded for the additional premium.

8. Rules Pertaining to Group or Quasi-Group Implications (Section 14)

> "An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact."

a. Cancer Extras Rider

Violation 1: The use of the term "preferred" policy holders implies that the prospective insureds enjoy special underwriting rates or privileges when such is not the case.

b. Cancer Increase Rider

Violation 1: The use of the term "preferred" policy holders implies that the prospective insureds enjoy special underwriting rates or privileges when such is not the case.

9. Rules Pertaining to Statements About an Insurer (Section 16)

> "An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation."

a. Cancer Increase Rider

Violation 1: Statements concerning the company's position in the insurance industry, the adequacy of present coverage and the insurance expertise of the Chairman are misleading by implication because they imply that the company's insurance policies are tailored to meet the particular needs of persons affected by cancer when the claims payment practices and benefit structure of the policies would imply otherwise.

B. Regulations 1973

1. Rules Pertaining to Form and Content of Marketing Method (Section 5A.-C.)

> "A. A marketing method for a health insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether a marketing method has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the

"marketing method may be reasonably expected to create upon a person of average education or intelligence, within the segment of a public to which it is directed.

"B. Marketing methods shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall be considered misleading.

"C. In determining whether a marketing method has the capacity or tendency to mislead, the Commissioner of Insurance may consider as misleading the failure to disclose to a purchaser or a prospective purchaser any fact, the disclosure of which may have influenced the purchaser or prospective purchaser not to enter into the transaction."

a. Cancer Extras Rider

Violation 1: The cumulative effect of violations 1-13 above under Regulation 1-74, Section 5 is a violation of Section 5A.-C. of the 1973 Regulations.

b. Cancer Increase Rider

Violation 1: The cumulative effect of violations 1-19 above under Regulation 1-74, Section 5 is a violation of Section 5A.-C. of the 1973 Regulations.

2. Rules Pertaining to Marketing Methods Addressing the Benefits Payable, Losses Covered or Premiums Payable (Section 6A.-C.)

"A. Deceptive Words, Phrases or Illustrations Prohibited

"(1) It is hereby prohibited to omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchasers is not satisfied, does not remedy misleading statements.

"(2) It shall be considered misleading to solicit an offer to contract for a health insurance policy without a clear and conspicuous disclosure of the premium rate for such policy.

"(3) It shall be considered misleading and therefore prohibited for a marketing method of a policy any of whose benefits are conditional upon confinement in a hospital or similar facility, to refer to the benefits or costs of the policy, or the risks against which the policy is intended to provide protection unless it shall also disclose both "clearly and conspicuously in accordance with Section 4 as well as on the application for such policy the extent (expressed as % of bills paid) to which the policy meets the costs of the short, average and long hospital stays defined in the attached Appendix A. 'Massachusetts Division of Insurance Hospital Cost Standards.'

"(4) It shall be considered misleading and therefore prohibited for a marketing method to contain or use words or phrases such a "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help pay your hospital and surgical bills"; "this policy will help full some of the gaps that Medicare and your present insurance leaves out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

"(5) It shall be considered misleading and therefore prohibited for a marketing method to present descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as, describing a waiting period as a "benefit builder", or stating "even pre-existing conditions are covered after two years." Words and phrases used in a marketing method to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

"(6) No marketing of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax free"; "extra cash"; "extra income"; "extra pay"; or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy is a disability or loss-of-time policy or will, in some way, enable them to make a profit from being hospitalized.

"(7) It shall be considered misleading and therefore prohibited for the marketing of a hospital or other similar facility confinement benefit to state that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit must be stated in the marketing method.

"(8) It shall be considered misleading and therefore prohibited for a marketing method of a policy covering only one disease or a list of specified diseases to imply coverage "beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

"(9) A marketing method for a policy providing benefits for specified illnesses only such as cancer or for specified accidents only, such as automobile accidents, shall be considered misleading and therefore prohibited unless it shall clearly and conspicuously state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following: 'THIS IS A LIMITED POLICY'; 'THIS IS A CANCER ONLY POLICY'; 'THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY'.

"(10) It shall be considered misleading and therefore prohibited for the marketing method of a direct response insurance product to imply that because 'no insurance agent will call and no commissions will be paid to agents' that it is 'a low cost plan' or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product, unless such is the fact, and is clearly substantiated in such advertising.

"(11) It shall be considered misleading and therefore prohibited for a marketing method to use photographs, illustrations, depictions or fictionalized accounts of illness or illness related subjects, or overemphasis of exceptional or catastrophic risk, or exaggeration of potential out-of-pocket costs of health care, or any other marketing method in such a way as to invite the purchase of health insurance for emotional rather than functional reasons.

"(12) When a policy is marketed whose benefits are intended to supplement and not duplicate those of Medicare, it shall be deemed misleading and therefore prohibited to market such a policy unless the benefits of the policy are prominently disclosed using the following scheme of characterization:

"A. In-patient Hospital Benefits
"B. In-patient Physicians Benefits
"C. Out-of-Hospital Benefits
"D. Benefits in Extended Care Facilities
"E. Benefits in Nursing Homes
"F. Other Benefits.

"In general the disclosure of benefits in each category will include at least:

"1. the extent to which MEDICARE deductibles are covered;

"2. the extent to which the co-insurance portions of MEDICARE are covered;

"3. the extent to which no benefits are payable.

"In disclosing the benefits provided, all of the above categories (A-F) shall always be portrayed, whether or not benefits are provided in those categories. When on benefits are provided in a given category -- statements such as 'No In Patient Doctors Benefits Provided', 'No benefits in Nursing Homes Provided', 'No other benefits provided' must be used.

"The disclosure required herein shall be made both in compliance with Section 4 of this regulation and on the application used in soliciting an offer to contract for such a policy. Compliance with this section for Medicare supplement policies shall be deemed as a proper substitute for both the application disclosure requirements of Section 7A and the disclosure requirements of Section 6A(3).

"B. Exceptions, Reductions and Limitations

"(1) When a marketing method refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific benefit, or the loss for which such benefit is payable, it shall be considered misleading and therefore prohibited unless it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the marketing method would have the capacity or tendency to mislead or deceive.

"(2) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date benefits begin to accrue for such loss, a marketing method which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods or be considered misleading and therefore prohibited.

"(3) A marketing method shall not use the words 'only'; 'just'; 'merely'; 'minimum'; or similar words or phrases to describe the applicability of any exceptions and reductions such as: 'This policy is subject to the following minimum exceptions and reductions' or it shall be considered to be misleading and therefore prohibited.

"C. Pre-Existing Conditions

"(1) A marketing method shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy or it shall be considered misleading and therefore prohibited. The use "of the term 'pre-existing condition' without an appropriate definition or description shall not be used or it shall be considered misleading and therefore prohibited.

"In this regard it shall be considered misleading and therefore prohibited to define the nature of 'pre-existing condition' exclusions using such terms as 'manifested, contracted and commenced' or the like without a clear and unambiguous explanation of the operational meaning of such terms accurately reflecting the company's claim practice in denying claims for this reason.

"(2) When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder or it shall be considered misleading and therefore prohibited. This rule prohibits the use of the phrase 'no medical examination required' and phrases of similar import, but does not prohibit explaining 'automatic issue'. If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required or it shall be considered misleading and therefore prohibited."

a. Cancer Extras Rider

Violation 1: The cumulative effect of violations 1-11 under Section 6A. of Regulation 1-74 and violations 1- 3 of Section 6B. and C. is a violation of Sections 6A.-C. of Regulation 1973.

Violation 2: The use of a fictionalized account of illness and statements such as "your life hangs in the balance" combined with the emphasis on the catastrophic risks associated with cancer invite the purchaser of the rider for emotional rather than functional reasons.

Violation 3: The rider offered is intended to be in addition to Medicare in some cases. The disclosure of benefits is inadequate because it fails to include the extent to which Medicare deductibles are covered; the extent to which co-insurance portions of Medicare are covered, and the extent to which no benefits are payable.

Violation 4: The benefits are inadequately disclosed because they fail to utilize or designate the required categories of benefits, to wit: In-Hospital Benefits, In-Patient Benefits, Out of Hospital Benefits, Benefits, Extended Care Facilities Benefits, Nursing Home Benefits and Other Benefits.

b. Cancer Increase Rider

Violation 1: The cumulative effect of violations 1-12 under Section 6A. of Regulation 1-74 and violations 1-4 of Sections 6.B. and C. is a violation of Sections 6A.-C. of Regulation 1973.

Violation 2: The overemphasis on the exceptional and catastrophic risk of cancer and the exaggeration of potential out-of-pocket costs, combined with the emphasis on the 33 1/3% increase, invites the purchase of this rider for emotional rather than functional reasons.

Violation 3: The rider offered is intended to be in addition to Medicare in some cases. The disclosure of benefits is inadequate because it fials to include the extent to which Medicare deductibles are covered, the extent to which co-insurance portions of Medicare are covered and the extent to which no benefits are payable.

Violation 4: The benefits are inadequately disclosed because they fail to utilize or designate the required categories of benefits, to wit: In-Hospital Benefits, In-Patient Benefits, Out of Hospital Benefits, Benefits in Extended Care Facilities, Benefits in Nursing Homes and Other Benefits.

3. Rules Pertaining to Form and Contents of Application (Section 7)

> "When a person uses an application form to be completed by the applicant as an offer to contract for a health insurance product, such application form shall contain statements disclosing to the applicant the nature of the policy offered for sale. In complying with this section of the regulations the following guidelines as to the contents and applicability of disclosure requirements shall be used:
>
> "(A) If the application is used for a policy any of whose benefits are contingent upon hospital confinement and where benefits payable represent less than 50% of the cost of an average hospitalization as specified in the Massachusetts Hospital Cost Standards then the following statement must appear on the application: (Not applicable to MEDICARE supplements -- See Sec. 6A(12).)
>
> "'This policy is supplemental in its coverage and is meant to be purchased in addition to basic health insurance. This policy pays for (Statistic supplied by marketer) % of the cost of an average stay in a Massachusetts Hospital as defined by the Mass. Division of Insurance Hospital Cost Standards.'
>
> "(B) If the advertised policy contains a provision which allows the insurer to deny claims for any loss, where the cause of such loss is in some manner traceable to a condition existing prior to the effective date of the policy the application shall state clearly and unambiguously in negative terms the nature and extent of that exclusion in accordance with guidelines spelled out in Sec. 6C(1).

"(C) If the application is for a policy whose benefits are subject to a waiting period either of the deductible kind e.g. '5th day for sickness' or of the one-time exclusionary kind, '30 day' or '6 months for certain conditions', the application must disclose in negative terms the nature of such exclusion.

"(D) The application must disclose for all health policies whether or not and to what extent benefits are or are not contingent upon hospital confinement.

"(E) The application must disclose the premium rate for the policy being solicited.

"(F) The application must disclose clearly and unambiguously the terms of renewability and premium guarantee if any.

"(G) At the completion of the above required statements of disclosure, space shall be made for the applicant's signature acknowledging understanding of such disclosures."

a. Cancer Extras Rider

Violation 1: The application fails to include the required statement concerning actual hospital costs as defined by the Massachusetts Division of Insurance Hospital Cost Standards.

Violation 2: The application fails to state clearly and unambiguously in negative terms the nature and extent of the exclusion for pre-existing conditions or conditions diagnosed within the first 120 days of coverage.

Violation 3: The application fails to disclose the extent to which benefits are contingent upon hospital confinement.

Violation 4: The application fails to disclose adequately the premium rate for the policy solicited.

Violation 5: The application fails to disclose adequately the terms of renewability and premium guarantee.

b. Cancer Increase Rider

Violation 1: The application fails to include the required statement concerning actual hospital costs as defined by the Massachusetts Division of Insurance Hospital Cost Standards.

Violation 2: The application fails to state clearly and unambiguously in negative terms the nature and extent of the exclusion for pre-existing conditions or conditions diagnosed within the first 120 days of coverage.

Violation 3: The application fails to disclose the extent to which benefits are contingent upon hospital confinement.

Violation 4: The application fails to disclose adequately the premium rate for the policy solicited.

Violation 5: The application fails to disclose adequately the terms of renewability and premium guarantee.

4. Rules Pertaining to Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination (Section 8)

"When a marketing method refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modification of reasons, in a manner which shall not minimize or render obscure the qualifying conditions or it shall be considered misleading and therefore prohibited.

"In this regard where there is a guarantee of renewability and/or premium which is conditional either on renewal of all such policies or premium adjustment on all such policies it will be considered misleading unless the marketing method clearly and conspicuously discloses that the insurer has the right to non-renew or to change premium levels at its choice and without specific approval of any state authority."

a. Cancer Extras Rider

Violation 1: Violation 1 under Regulation 1-74, Section 7 is a violation of Regulation 1973, Section 8.

b. Cancer Increase Rider

Violation 1: Violation 1 under Regulation 1-74, Section 7 is a violation of Regulation 1973, Section 8.

5. Rules Pertaining to Testimonials or Endorsements by Third Parties Section 9A.-D.

"A. Testimonials used in marketing methods must be genuine, represent the current opinion of the author, be applicable to the policy marketed and be accurately reproduced or it shall be considered misleading and therefore prohibited. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the marketing method, including such statement, is subject to all the provisions of these rules.

"B. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the marketing method or it shall be considered misleading and therefore prohibited. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the marketing method by language substantially as follows: 'Paid endorsement.' This rule does not require disclosure of union 'scale' wages required by union rules if the payment is actually for such 'scale' for TV or radio performances. The payment of substantial amounts, directly or indirectly for 'travel and entertainment' for filming or recording of TV or radio advertisements removes the filming or recording from the category of an unsolicited testimonial and requires disclosure of such compensation.

"C. A marketing method shall not state or imply that an insurer or a policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary or other financial relationship between an organization and the insurer is disclosed, or it shall be considered misleading and therefore prohibited. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the marketing method or it shall be considered misleading and therefore prohibited.

"D. In order to assure compliance when a testimonial refers to benefits received under a policy, the specific "claim data, including claim number, data of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time."

a. Cancer Extras Rider

Violation 1: The testimonials used do not necessarily all refer to the "cancer extras" rider. While all quoted persons are or were policy holders at the time of the endorsement, not all were covered by the cancer extras rider; thus, the use of the testimonial as an aid to the sale of the rider is misleading. ✓

Violation 2: The testimonials are not accurately reproduced and omit certain phrases. An entire paragraph citing unreasonable claims payment delay was omitted from the Levy testimonial. A phrase of similar import was omitted from the Case testimonial.

Violation 3: Many of the testimonials were solicited by the company and all received the sum of at least $1.00 for the use of their comments. The company states to the author of the testimonial that the payment of such sum is intended to be a "token of company appreciation" ✓ when it is, in fact, the payment of consideration to said author for a signed release for the use of the testimonial. Thus, the testimonials are obtained deceptively by the company and then used as unsolicited testimonials at a later date.

6. Rules Pertaining to Use of Statistics (Section 10)

> "A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.
>
> B. An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or generous" or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.
>
> C. The source of any statistics used in an advertisement shall be identified in such advertisement."

a. Cancer Extras Rider

Violation 1: The recitation of hypothetical situations concerning the course of cancer treatment or costs associated therewith is misleading and deceptive and constitute the use of irrelevant facts in the promotion of the rider. The advertisement implies that the cited expenditures would be covered by the policy.

Violation 2: The statements of benefits commencing with "you'll collect" are misleading and imply an ease in the collection of said benefits which is not consistent with the underlying facts of cancer treatment or with company practices and claim payment history.

b. Cancer Increase Rider

Violation 1: The use of statistics from the American Cancer Society and statements implying that this rider has been developed in response to a popular demand by "millions of Americans" is misleading and deceptive. First, these statements are not facts and second, even as fact they are irrelevant. The statement that the average hospital bill is $158 and that the average cancer hospital stay is double the stay of other hospitalization constitutes the use of irrelevant facts because it does not reveal the components of the average daily hospital bill or the usual length of hospitalization.

Violation 2: The emphasis on the 33 1/3% increase in benefits is misleading and implies claims settlement practices which are beyond the actual terms of the policy. First, many benefits are paid on the basis of actual costs, thus the increase may be irrelevant. Second, the advertisement fails to include actual costs or payments history so that the policy holder can accurately evaluate the utility of the increased benefits. ✓

7. Rules Pertaining to Identification of Plan or Number of Policies (Section 11)

> "A. When a choice of the amount of benefits is referred to, a marketing method shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected or it shall be considered misleading and therefore prohibited.
>
> "B. When a marketing method refers to various benefits which may be contained in two or more policies other than group master policies, the marketing method shall disclose that such benefits are provided only through a combination of such policies or it shall be considered misleading and therefore prohibited."

a. Cancer Extras Rider

Violation 1: The policy fails to explain or disclose fully the extent to which benefits are paid in addition to the benefits of the base policy or instead of the benefits of the base policy. For instance, intensive care benefits would generally be provided while the patient is in the hospital. Thus, it is unclear whether the policy holder would collect the offered intensive care benefits in addition to the regular hospital benefits or instead of said benefits. The same is true of skilled nursing facilities which in some cases are associated with hospitals or other institutions which may qualify for daily hospital benefits.

b. Cancer Increase Rider

Violation 1: The advertisement fails to disclose the extent to which the rider augments or substitutes for the benefits mentioned in other cancer riders, such as Cancer Extras, After Hospital, Cancer Intensive Care and Cancer Skilled Nursing. If any of these other riders are owned by the policy holder and such other riders actually increase benefits to the extent promised, the $200,000 maximum limits would render the relationship of said rider to this risk.

8. Rules Pertaining to Group or Quasi-Group Implications (Section 15)

> "A marketing method for a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact or it shall be considered misleading and therefore prohibited."

a. Cancer Extras Rider

Violation 1: The use of the term "preferred" policy holders implies that the prospective insureds enjoy special underwriting rates or privileges when such is not the case. ✓

Violation 2: The pictorial representation of cancer facts and statistics, together with the statement of policy benefits tends to materially mislead the consumer in the evaluation of the product.

3. Regulations of the Attorney General, Regulation XV.A. - C. - General

> "Without limiting the scope of any other rule, regulation or statute, an act or practice is a violation of Chapter 93A, Section 2, if:
>
> "A. It is oppressive or otherwise unconscionable in any respect; or
> B. Any person or other legal entity subject to this act fails to disclose to a buyer or prospective buyer any fact, the disclosure of which may have influenced the buyer or prospective buyer not to enter into the transaction; or
> C. It fails to comply with existing statutes, rules, regulations or laws, meant for the protection of the public's health, safety, or welfare promulgated by the Commonwealth or any political subdivision thereof intended to provide the consumers of this Commonwealth protection;"

a. Cancer Extras Rider

Violation 1: It is unconscionable to sell a policy which, under certain circumstances, makes it literally impossible to collect the benefits promised. ✓

Violation 2: It is unfair and deceptive to fail to disclose material facts (such as loss ratios, denial rates, actual hospital and related charges and exclusions and limitations) to a prospective buyer because the disclosure of these material facts might have influenced the buyer not to enter into the transaction. ✓

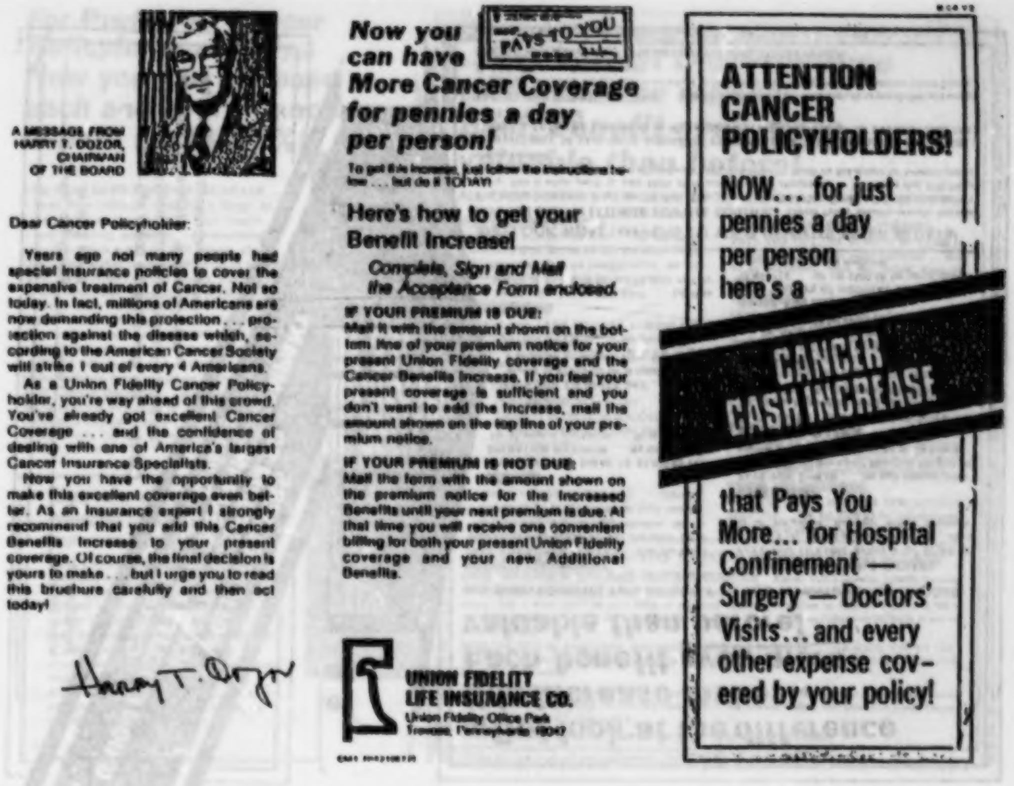
Violation 3: Each and every of the aforementioned violations and the cumulative effect thereof is a violation of Regulation XV.C.

b. Cancer Increase Rider

Violation 1: It is unconscionable to sell a policy which, under certain circumstances, makes it literally impossible to collect the benefits promised.

Violation 2: It is unfair and deceptive to fail to disclose material facts (such as loss ratios, denial rates, actual hospital and related charges and exclusions and limitations) to a prospective buyer because the disclosure of these material facts might have influenced the buyer not to enter into the transaction.

Violation 3: Each and every of the aforementioned violations and the cumulative effect thereof is a violation of Regulation XV.C.



A MESSAGE FROM
HARRY T. DOZOR,
CHAIRMAN
OF THE BOARD

Dear Cancer Policyholder:

Years ago not many people had special insurance policies to cover the expensive treatment of Cancer. Not so today. In fact, millions of Americans are now demanding this protection . . . protection against the disease which, according to the American Cancer Society will strike 1 out of every 4 Americans.

As a Union Fidelity Cancer Policyholder, you're way ahead of this crowd. You've already got excellent Cancer Coverage . . . and the confidence of dealing with one of America's largest Cancer Insurance Specialists.

Now you have the opportunity to make this excellent coverage even better. As an insurance expert I strongly recommend that you add this Cancer Benefits Increase to your present coverage. Of course, the final decision is yours to make . . . but I urge you to read this bruchure carefully and then act today!

Harry T. Dozor

Now you can have More Cancer Coverage for pennies a day per person!

To get this increase, just follow the instructions below . . . but do it TODAY!

Here's how to get your Benefit Increase!

Complete, Sign and Mail the Acceptance Form enclosed.

IF YOUR PREMIUM IS DUE:
Mail it with the amount shown on the bottom line of your premium notice for your present Union Fidelity coverage and the Cancer Benefits Increase. If you feel your present coverage is sufficient and you don't want to add the increase, mail the amount shown on the top line of your premium notice.

IF YOUR PREMIUM IS NOT DUE:
Mail the form with the amount shown on the premium notice for the Increased Benefits until your next premium is due. At that time you will receive one convenient billing for both your present Union Fidelity coverage and your new Additional Benefits.

**UNION FIDELITY
LIFE INSURANCE CO.**
Union Fidelity Office Park
Trevose, Pennsylvania 19047

ATTENTION CANCER POLICYHOLDERS!

NOW... for just pennies a day per person here's a

CANCER CASH INCREASE

that Pays You More... for Hospital Confinement — Surgery — Doctors' Visits... and every other expense covered by your policy!

...But look at the difference this increase makes... Each benefit even more valuable than before!

ALL CASH BENEFITS PAID DIRECTLY TO YOU OR ANYONE YOU CHOOSE.

HOSPITAL CONFINEMENT:
PAYS YOU $120.00 PER DAY . . . For the first 7 consecutive days; $90.00 per day thereafter. (After 90 consecutive days of hospitalization, see Extended Hospital Benefits below.)

SURGICAL:
PAYS YOU FROM $60.00 TO $1,000.00 PER OPERATION MAXIMUM . . . No limit on number of surgical procedures . . . In or out of the hospital.

PHYSICIAN:
PAYS YOU $20.00 PER DAY . . . Lifetime benefit of $1,200.00 for in hospital visits by a physician or surgeon, other than surgeon performing surgery.

NURSING:
PAYS YOU $40.00 PER DAY . . . Lifetime benefit of $1,200.00 for special daily care by an RN or LPN in the hospital.

X-RAY-RADIUM-COBALT THERAPY:
PAYS YOU LIFETIME BENEFIT OF $2,000.00 . . . for X-ray, radium or cobalt treatment . . . even as an out-patient. Does not include diagnostic X-ray.

ANESTHESIA:
PAYS YOU $140.00 . . . for each internal operation; $40.00 for skin cancer operation. No limit on number of operations . . . In or out of the hospital.

BLOOD AND PLASMA:
PAYS YOU LIFETIME BENEFIT OF $600.00 . . . for charges incurred for blood and plasma even as an out-patient. No maximum on benefits for leukemia.

AMBULANCE:
PAYS YOU LIFETIME BENEFIT OF $1,000.00 . . . for transportation to and from the hospital, limited to $100.00 for each confinement period.

DRUGS AND MEDICINES:
PAYS YOU 10% OF HOSPITAL CONFINEMENT BENEFITS . . . UP TO $500.00 for actual charges incurred for drugs and medicines.

AND LOOK WHAT HAPPENS TO YOUR BENEFITS AFTER 90 DAYS!

PAYS YOU CASH IN EXTENDED HOSPITAL BENEFITS: Cancer Policy benefits actually increase after you've been hospitalized past 90 days. Even though your basic benefits are exhausted, you needn't worry. This is when you'll be paid 100% of all actual hospital charges, up to $333.33 a day, $10,000 a month, beginning on the 91st day of continuous hospitalization . . . with no deductions for benefits you've already received.

BENEFITS WILL BE PAID UNTIL DISCHARGE FROM THE HOSPITAL . . . OR UNTIL YOU'VE COLLECTED A TOTAL OF $200,000.00 IN MAXIMUM LIFETIME BENEFITS, UP TO 3 YEARS FROM THE DATE OF DIAGNOSIS.

EXCLUSIONS AND LIMITATIONS: Benefits are subject to the same exclusions and limitations stated in your present cancer policy. Persons who have or had cancer are not eligible. This protection covers Cancer, Hodgkins Disease and Leukemia only.

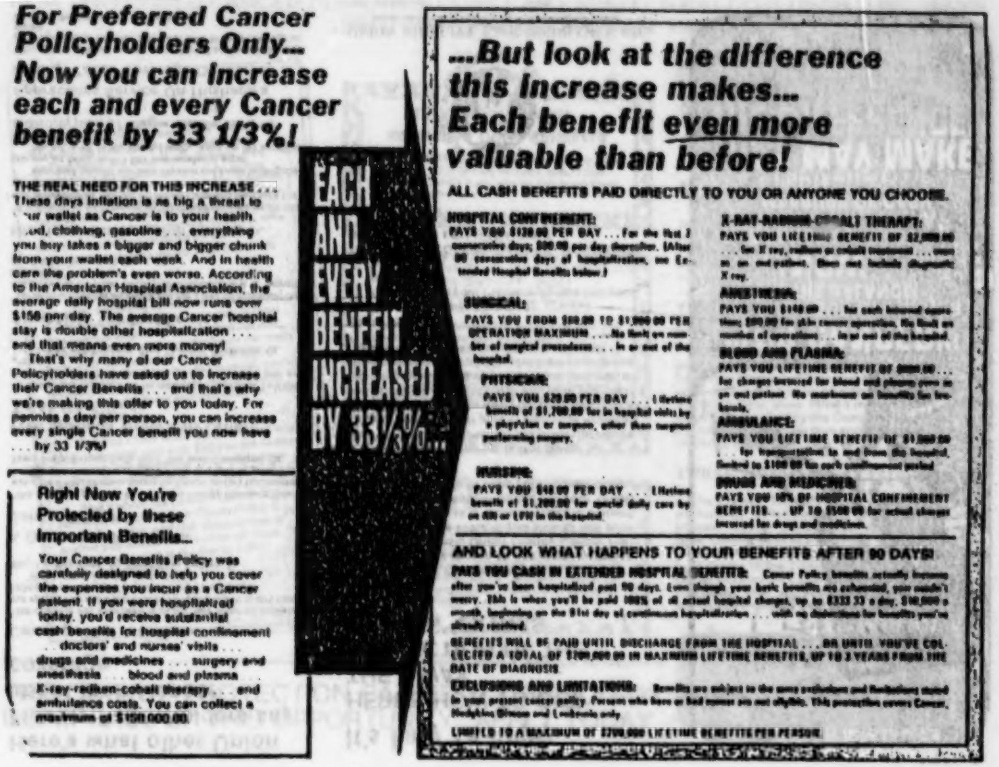
LIMITED TO A MAXIMUM OF $200,000 LIFETIME BENEFITS PER PERSON.

EACH
AND
EVERY
BENEFIT
INCREASED
BY 33⅓%...

**POLICYHOLDERS
ACCEPTANCE FORM TO
UNION FIDELITY LIFE INSURANCE COMPANY
Cancer Benefits Division**

I hereby represent that to the best of my knowledge, information and belief, no person insured under this policy has developed Cancer in any form since the policy effective date.

Signature of Main Insured__________ Date________ Enter Cancer Policy No. Here________



For Preferred Cancer Policyholders Only... Now you can increase each and every Cancer benefit by 33 1/3%!

THE REAL NEED FOR THIS INCREASE . . . These days inflation is as big a threat to your wallet as Cancer is to your health . . . food, clothing, gasoline . . . everything you buy takes a bigger and bigger chunk from your wallet each week. And in health care the problem's even worse. According to the American Hospital Association, the average daily hospital bill now runs over $158 per day. The average Cancer hospital stay is double other hospitalization . . . and that means even more money!

That's why many of our Cancer Policyholders have asked us to increase their Cancer Benefits . . . and that's why we're making this offer to you today. For pennies a day per person, you can increase every single Cancer benefit you now have . . . by 33 1/3%!

Right Now You're Protected by these Important Benefits...

Your Cancer Benefits Policy was carefully designed to help you cover the expenses you incur as a Cancer patient. If you were hospitalized today, you'd receive substantial cash benefits for hospital confinement . . . doctors' and nurses' visits . . . drugs and medicines . . . surgery and anesthesia . . . blood and plasma . . . X-ray-radium-cobalt therapy . . . and ambulance costs. You can collect a maximum of $150,000.00.

EACH AND EVERY BENEFIT INCREASED BY 33⅓%...

...But look at the difference this increase makes... Each benefit even more valuable than before!

ALL CASH BENEFITS PAID DIRECTLY TO YOU OR ANYONE YOU CHOOSE.

HOSPITAL CONFINEMENT:
PAYS YOU $120.00 PER DAY . . . for the first [illegible] consecutive days; $80.00 per day thereafter. (After 90 consecutive days of hospitalization, see Extended Hospital Benefits below.)

SURGICAL:
PAYS YOU FROM $[illegible] TO $1,000.00 PER OPERATION MAXIMUM . . . No limit on number of surgical procedures . . . in or out of the hospital.

PHYSICIAN:
PAYS YOU $20.00 PER DAY . . . lifetime benefit of $1,700.00 for in hospital visits by a physician or surgeon, other than surgeon performing surgery.

NURSING:
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PAYS YOU LIFETIME BENEFIT OF $2,000.00 . . . for X ray, radium or cobalt treatment . . . even as an out-patient. Does not include diagnostic X ray.

ANESTHESIA:
PAYS YOU $140.00 . . . for each listed operation; $[illegible] for skin cancer operation. No limit on number of operations . . . in or out of the hospital.

BLOOD AND PLASMA:
PAYS YOU LIFETIME BENEFIT OF $[illegible] . . . for charges incurred for blood and plasma given in or out patient. No maximum on benefits for [illegible].

AMBULANCE:
PAYS YOU LIFETIME BENEFIT OF $1,000.00 . . . for transportation to and from the hospital, limited to $100.00 for each confinement period.

DRUGS AND MEDICINES:
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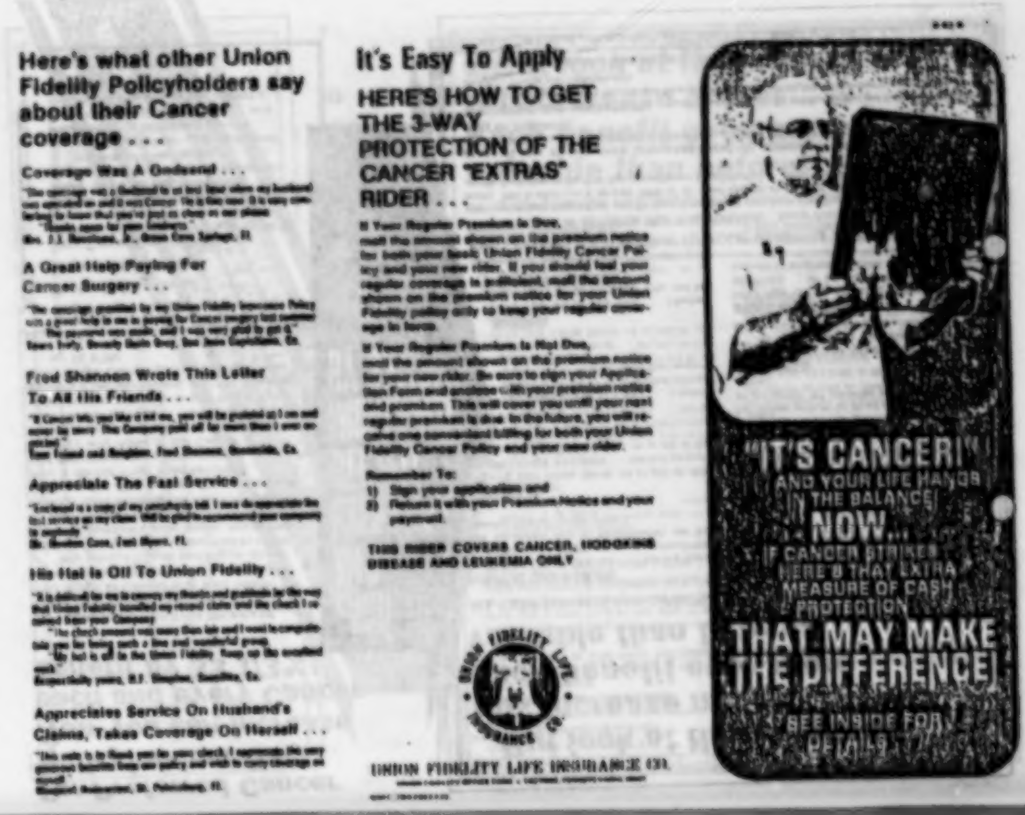

Here's what other Union Fidelity Policyholders say about their Cancer coverage . . .

Coverage Was A Godsend . . .

[illegible]

A Great Help Paying For Cancer Surgery . . .

[illegible]

Fred Shannon Wrote This Letter To All His Friends . . .

[illegible]

Appreciate The Fast Service . . .

[illegible]

His Hat Is Off To Union Fidelity . . .

[illegible]

Appreciates Service On Husband's Claims, Takes Coverage On Herself . . .

[illegible]

It's Easy To Apply

HERE'S HOW TO GET THE 3-WAY PROTECTION OF THE CANCER "EXTRAS" RIDER . . .

If Your Regular Premium Is Due, mail the amount shown on the premium notice for both your basic Union Fidelity Cancer Policy and your new rider. If you should feel your regular coverage is sufficient, mail the amount shown on the premium notice for your Union Fidelity policy only to keep your regular coverage in force.

If Your Regular Premium Is Not Due, mail the amount shown on the premium notice for your new rider. Be sure to sign your Application Form and enclose with your premium notice and premium. This will cover you until your next regular premium is due. In the future, you will receive one convenient billing for both your Union Fidelity Cancer Policy and your new rider.

Remember To:

1) Sign your application and
2) Return it with your Premium Notice and your payment.

THIS RIDER COVERS CANCER, HODGKINS DISEASE AND LEUKEMIA ONLY

UNION FIDELITY LIFE INSURANCE CO.

UNION FIDELITY LIFE INSURANCE CO.
"IT'S CANCER!"
AND YOUR LIFE HANGS IN THE BALANCE!
NOW...
IF CANCER STRIKES HERE'S THAT EXTRA MEASURE OF CASH PROTECTION
THAT MAY MAKE THE DIFFERENCE!
SEE INSIDE FOR DETAILS

NOW PREFERRED CANCER POLICYHOLDERS CAN EXPAND THEIR COVERAGE 3 BIG WAYS ...WITH THE CANCER "EXTRAS" RIDER!

"It's Cancer!" [illegible]

[illegible]

① PAYS YOU
INTENSIVE CARE BENEFITS

[illegible]

② PAYS YOU
AFTER-HOSPITAL CASH

[illegible]

③ PAYS YOU
NURSING HOME BENEFITS

[illegible]

[illegible]

ALL CASH PAID DIRECT TO YOU

That's right! All these cash benefits are paid directly to you, or anyone you choose. And you're paid regardless of how much you receive from any other insurance plan — including Medicare, Group Insurance . . . even your insurance with us. And there are no reductions in benefits for people over 65. . . ever!

YOU WON'T BE SINGLED OUT FOR A RATE INCREASE

No matter how many claims you submit or how your health changes, you can never be singled out for a rate increase. Rates can be raised only if the same action is taken on all riders of this type ([illegible]) in your state. What's more, your Rider can never be cancelled by the Company as long as your premiums are paid on time and your basic Policy remains in force.

THESE ARE THE EXCLUSIONS

The Cancer "Extras" Rider is subject to the same exclusions, definitions and provisions as your present Cancer Policy. Post-operative Intensive Care Confinement in a Recovery Room of less than 24 hours duration is not covered. Cancer first manifested prior to the Effective Date of this Rider shall not be covered for 2 years from such Effective Date. Of course, after two years, pre-existing conditions will be covered (one year in [illegible]).

[illegible]

THIS "EXTRA" PROTECTION CAN BE YOURS TODAY! DON'T PASS UP THIS OPPORTUNITY...APPLY TODAY

EXHIBIT 5

I. Review of the Medicare Supplement Insurance Plan Marketed through the National Senior Citizens Group Insurance Trust

Advertising Materials Reviewed:

UFLIC Form Number BA 125B
UFLIC Form Number S 132
UFLIC Form Number L 148
UFLIC Form Number BS 148
UFLIC Form Number H 148

Underlying Insurance Policy:

1. UFLIC Form Number DRI 8130 MA
   Filed for approval by the Commonwealth: June 19, 1978
   Approved by the Commissioner: July 10, 1978
2. UFLIC Form Number DRI 8120
   Filed for approval by the Commonwealth: May 31, 1978
   Approved by the Commissioner: June 8, 1978
3. UFLIC Form Number DRI 8140 MA
   Filed for approval by the Commonwealth: June 14, 1978
   Approved by the Commissioner: June 20, 1978

II. Analysis of Benefits

A. If an expense would be covered by Medicare except for the deductible, the Supplement will pay as follows:

Day 1 through day 60	$144.00
Day 61 through day 90	$1080.00
Day 91 through day 150	$4320.00

TOTAL PAID AFTER 150 DAYS OF INPATIENT TREATMENT	$5544.00
TOTAL REMAINING COVERAGE	$44456.00

NUMBER OF DAYS OF INPATIENT TREATMENT NECESSARY TO COLLECT TOTAL BENEFITS 309 DAYS

In general, coverage is conditioned upon the same restictions, limitations and exclusions as Medicare Part A. Medicare pays only those charges which are reasonable and necessary and not custodial. To colect Medicare Part A benefits, the following coditions must be satisfied: First, the doctor must prescribe the treatment; Second, the care must be of a kind only hospitals can provide; Third, the hospital must be a participating institution; Fourth, the Utilization Committee of the hospital must not disapprove the treatment.

The following are some of the general categories of services not covered by Medicare Part A:

1. Doctor Services
2. Personal convenience items
3. Private duty nurses
4. Extra charges for private room unless ordered by a physician for medical reasons
5. 3 pints of blood
6. Accupuncture
7. Custodial care
8. Drugs or medicines purchased by the insured
9. Self-administered injections
10. Routine physical examinations

III. Legal Analysis

A. Purpose

In general it is deemed to be misleading to solicit an offer to contract for health insurance without a clear and conspicuous disclosure of the following:

1. The extent and nature of the coverage offered.
2. The extent to which the coverage meets the potential risk.
3. The cost of the coverage.

All marketing methods and practices pertaining to the sale of health insurance are subject to the minimum standards and guidelines of conduct established by the rules and regulations promulgated pursuant to Massachusetts General Laws Chapters 175, 176D and 93A, among others. These regulations and rules are intended to assure truthful and adequate disclosure of all material and relevant information in the advertising and marketing of this insurance. All information required to be disclosed by these rules shall be presented conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or disclosed in any manner so as to be confusing or misleading.

B. Regulations Promulgated in Accordance with Massachusetts General Laws Chapter 176D, Section 11 to Identify Violations of Chapter 176D, Section 3, Effective September 28, 1973

1. Rules Pertaining to the Form and Content of Marketing Method (Section 5)

"A. A marketing method for a health insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether a marketing method has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the marketing method may be reasonably expected to create upon a person of average education or intelligence, within the segment of a public to which it is directed.

"B. Marketing methods shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall be considered misleading.

"C. In determining whether a marketing method has the capacity or tendency to mislead, the Commissioner of Insurance may consider as misleading the failure to disclose to a purchaser or a prospective purchaser any fact, the disclosure of which may have influenced the purchaser or prospective purchaser not to enter into the transaction."

Violation 1: The employment of the National Senior Citizens Group Trust as a marketing method is misleading and deceptive because it fails to disclose material facts pertaining to the relationship between the company and the trust. In fact, the trust is nothing but a marketing device developed and completely controlled by the company. The trust itself, although a legal entity, is without independent subsistence or activity. All activities of the trust, including the publication of the National Senior Citizens Sentinel, are controlled and directed by the company.

Violation 2: The materials employed in the sale of Medicare supplement insurance plan are not sufficiently clear and complete to avoid misleading the prospective policy holder. The materials omit relevant information as to the extent to which the potential health care risks of the elderly are covered. The omitted information includes facts concerning the sufficiency of the Medicare plan itself, actual health costs associated with the treatment of the elderly and clear statements as to exceptions, limitations and exclusions.

Violation 3: The marketing materials employed are misleading in fact and implication because they assume a familiarity with insurance terminology employed by Medicare. They create or permit the impression that the supplement will pay everything that is not covered by Medicare while in fact the supplement is subject to the same reductions, limitations and exclusions as Medicare.

2. Rules Pertaining to Marketing Methods Addressing the Benefits Payable, Losses Covered and Premiums Payable (Section 6)

"A. Deceptive Words, Phrases or Illustrations Prohibited

"(1) It is hereby prohibited to omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchasers is not satisfied, does not remedy misleading statements.

"(2) It shall be considered misleading to solicit an offer to contract for a health insurance policy without a clear and conspicuous disclosure of the premium rate for such policy.

"2. the extent to which the co-insurance portions of MEDICARE are covered;
"3. the extent to which no benefits are payable.

"In disclosing the benefits provided, all of the above categories (A-F) shall always be portrayed, whether or not benefits are provided in those categories. When on benefits are provided in a given category -- statements such as 'No In Patient Doctors Benefits Provided', 'No benefits in Nursing Homes Provided', 'No other benefits provided' must be used.

"The disclosure required herein shall be made both in compliance with Section 4 of this regulation and on the application used in soliciting an offer to contract for such a policy. Compliance with this section for Medicare supplement policies shall be deemed as a proper substitute for both the application disclosure requirements of Section 7A and the disclosure requirements of Section 6A(3).

"B. Exceptions, Reductions and Limitations

"(1) When a marketing method refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific benefit, or the loss for which such benefit is payable, it shall be considered misleading and therefore prohibited unless it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the marketing method would have the capacity or tendency to mislead or deceive.

"(2) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date benefits begin to accrue for such loss, a marketing method which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods or be considered misleading and therefore prohibited.

"(3) A marketing method shall not use the words 'only'; 'just'; 'merely'; 'minimum'; or similar words or phrases to describe the applicability of any exceptions and reductions such as: 'This policy is subject to the following minimum exceptions and reductions' or it shall be considered to be misleading and therefore prohibited.

"C. Pre-Existing Conditions

"(1) A marketing method shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy or it shall be considered misleading and therefore prohibited. The use "of the term 'pre-existing condition' without an appropriate definition or description shall not be used or it shall be considered misleading and therefore prohibited.

"In this regard it shall be considered misleading and therefore prohibited to define the nature of 'pre-existing condition' exclusions using such terms as 'manifested, contracted and commenced' or the like without a clear and unambiguous explanation of the operational meaning of such terms accurately reflecting the company's claim practice in denying claims for this reason.

"(2) When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder or it shall be considered misleading and therefore prohibited. This rule prohibits the use of the phrase 'no medical examination required' and phrases of similar import, but does not prohibit explaining 'automatic issue'. If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required or it shall be considered misleading and therefore prohibited."

Violation 1: All references to the National Senior Citizens Group Insurance Trust have the tendency to deceive the prospective purchaser because they give the appearance and impression that the trust is an independent entity specializing in providing adequate insurance coverage for the elderly. Misleading information and practices, including the publication of the Sentinel and citing circulation up to 5,000,000, create a false impression as to the representation and administration of said trust and therefore as to the extent of the policy offere

Violation 2: Statements that the coverage is available at low group rates have the capacity to mislead the prospective purchaser about usual premiums payable because it omits information about said usual premiums.

Violation 3: Continued references to supplement benefits as being directly related to in-hospital Medicare benefits without disclosing the exclusion applicable to in-hospital Medicare benefits is misleading because it fails to inform the prospective policy holder as to the limited nature of the coverage offered. By defining benefits as "eligible" or "covered" without defining said terms the material has the capacity to mislead the prospective purchaser.

Violation 4: It is deceptive and misleading to market the supplement as providing coverage for life and security for retirement years when in fact the master policy can be terminated on sixty days' notice by the company.

Violation 5: The premium rate for the supplement is misleading because the application and the initial premium indicate coverage can include a spouse for the same charge, yet the quoted premium is listed as being per person.

Violation 6: The policy is misleading because it fails to disclose clearly and conspicuously the extent to which the policy meets the costs of hospital stays as established by the Massachusetts Division of Insurance Hospital Cost Standards.

Violation 7: The promotional materials are misleading and deceptive because they employ statements such as "pays 100% of all eligible charges", "works hand in hand with Medicare" and "lifetime maximum of $50,000" and because the manner in which such statements are used minimizes and obscures exclusions from coverage and thereby exaggerates benefits beyond the terms of the policy.

Violation 8: Statements that the supplement pays "eligible" or covered benefits do not fairly and accurately disclose limitations, exceptions and reductions of the policy offered because they are not stated in a negative manner.

Violation 9: Statements such as "pays you in addition to any benefits received from Medicare or any other insurance" and "the benefits will be yours to spend as you see fit" have the capacity to lead the policy holder to believe that he can derive a profit from being hospitalized.

Violation 10: It is misleading for the materials to state a maximum benefits limit on the policy and that 100% of all eligible benefits are paid up to $144 a day without stating the number of days necessary to collect said limits.

Violation 11: It is misleading for the marketing method to exaggerate and overemphasize the increases associated with Medicare policies and to emphasize the security to be derived from membership in the National Senior Citizens Group Insurance Trust in such a way as to invite the purchase of the policy for emotional rather than functional reasons.

Violation 12: The marketing materials and the application are deficient because they fail to disclose and present adequately the coverage or lack of coverage in each of the following categories: In Hospital Benefits, In Patient Physicians Benefits, Out of Hospital Benefits, Benefits in Extended Care Facilities, Benefits in Nursing Homes and Other Benefits.

Violation 13: The marketing method is misleading because it fails to disclose clearly and completely the exceptions, reductions and limitations affecting the base provisions of the policy. The reference to the exceptions, reductions and limitations of the Medicare policy is not sufficient because it assumes a knowledge of such restrictions by the prospective policy holder.

Violation 14: The definition of "pre-existing condition" is not sufficiently and clearly defined because it fails to provide a clear and unambiguous explanation of the operational meaning of such a term which accurately reflects the company's practice in denying claims on the basis of pre-existing conditions.

Violation 15: The definition of pre-existing condition is under the section entitled "YOUR Questions Answered", which is on the enrollment form that the applicant uses to apply for coverage thus having the capacity to mislead or deceive the applicant as to the extent of exclusion.

3. Rules Pertaining to Form and Contents of Application (Section 7)

"When a person uses an application form to be completed by the applicant as an offer to contract for a health insurance product, such application form shall contain statements disclosing to the applicant the nature of the policy offered for sale. In complying with this section of the regulations the following guidelines as to the contents and applicability of disclosure requirements shall be used:

"(A) If the application is used for a policy any of whose benefits are contingent upon hospital confinement and where benefits payable represent less than 50% of the cost of an average hospitalization as specified in the Massachusetts Hospital Cost Standards then the following statement must appear on the application: (Not applicable to MEDICARE supplements -- See Sec. 6A(12).)

"'This policy is supplemental in its coverage and is meant to be purchased in addition to basic health insurance. This policy pays for (Statistic supplied by marketer) % of the cost of an average stay in a Massachusetts Hospital as defined by the Mass. Division of Insurance Hospital Cost Standards.'

"(B) If the advertised policy contains a provision which allows the insurer to deny claims for any loss, where the cause of such loss is in some manner traceable to a condition existing prior to the effective date of the policy the application shall state clearly and unambiguously in negative terms the nature and extent of that exclusion in accordance with guidelines spelled out in Sec. 6C(1).

"(C) If the application is for a policy whose benefits are subject to a waiting period either of the deductible kind e.g. '5th day for sickness' or of the one-time exclusionary kind, '30 day' or '6 months for certain conditions', the application must disclose in negative terms the nature of such exclusion.

"(D) The application must disclose for all health policies whether or not and to what extent benefits are or are not contingent upon hospital confinement.

"(E) The application must disclose the premium rate for the policy being solicited.

"(F) The application must disclose clearly and unambiguously the terms of renewability and premium guarantee if any.

"(G) At the completion of the above required statements of disclosure, space shall be made for the applicant's signature acknowledging understanding of such disclosures."

Violation 1: The application form, which is the designated enrollment form in the marketing materials, does not sufficiently disclose the extent and nature of the policy offered for sale. It fails to include information concerning pre-existing condition, contingency upon hospital confinement, premium rate, renewability and acknowledgment by the applicant.

4. Rules Pertaining to Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination (Section 8)

"When a marketing method refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modification of reasons, in a manner which shall not minimize or render obscure the qualifying conditions or it shall be considered misleading and therefore prohibited.

"In this regard where there is a guarantee of renewability and/or premium which is conditional either on renewal of all such policies or premium adjustment on all such policies it will be considered misleading unless the marketing method clearly and conspicuously discloses that the insurer has the right to non-renew or to change premium levels at its choice and without specific approval of any state authority."

Violation 1: The marketing method fails to disclose conspicuously and clearly that the insurer has the right to change premium levels or cancel the master policy without specific approval of state authority.

5. Rules Pertaining to Testimonials or Endorsements by Third Parties (Section 9)

"A. Testimonials used in marketing methods must be genuine, represent the current opinion of the author, be applicable to the policy marketed and be accurately reproduced or it shall be considered misleading and therefore prohibited. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the marketing method, including such statement, is subject to all the provisions of these rules.

"B. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the marketing method or it shall be considered misleading and therefore prohibited. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the marketing method by language substantially as follows: 'Paid endorsement.' This rule does not require disclosure of union 'scale' wages required by union rules if the payment is actually for such 'scale' for TV or radio performances. The payment of substantial amounts, directly or indirectly for 'travel and entertainment' for filming or recording of TV or radio advertisements removes the filming or recording from the category of an unsolicited testimonial and requires disclosure of such compensation.

"C. A marketing method shall not state or imply that an insurer or a policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary or other financial relationship between an organization and the insurer is disclosed, or it shall be considered misleading and therefore prohibited. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the marketing method or it shall be considered misleading and therefore prohibited.

"D. In order to assure compliance with a testimonial refers to benefits received under a policy, the specific "claim data, including claim number, data of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time."

Violation 1: The letter included among the promotional materials is misleading and deceptive because it fails to disclose that the person signing the letter, at the time of the writing of the letter, was an employee of the company and that his entire salary was paid by the company. It also fails to disclose that the administration of the trust was in fact performed by the marketing department of the company.

Violation 2: The National Senior Citizens Group Insurance Trust is formed, owned and controlled exclusively by the company, which fact is not disclosed in the marketing materials and therefore the omission of such fact is misleading. The same is true of the National Senior Citizens Sentinel.

6. Rules Pertaining to Use of Statistics (Section 10)

"A. A marketing method relating to the dollar amounts of claims paid, the time within which claims are paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts, or it shall be considered misleading and therefore prohibited. Such a marketing method shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

"B. A marketing method shall not represent or imply that claim settlements by the insurer are 'liberal' or 'generous' or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract, or it shall be considered misleading and therefore prohibited. An unusual amount paid for a unique claim for the policy marketed is misleading and shall not be used.

"C. The source of any statistics used in a marketing method shall be identified in such marketing method or it shall be considered misleading and therefore prohibited."

Violation 1: The marketing materials represent that most Medicare supplement claims are processed within five days. Such a statement does not accurately reflect the actual company practices. The source of such statement is not identified.

Violation 2: Statements pertaining to special discount prices available to the elderly and what 'many folks would be glad to pay' are irrelevant and unreliable and therefore misleading. There is no connection to this policy with regard to the former and the company has no statistics to back up the latter.

Violation 3: The statement that 25 million Americans will have to pay $770 more during a benefit period is misleading and irrelevant.

Violation 4: The statement that some persons have been stricken with illness or accident on the very day coverage commences is misleading, irrelevant and unsubstantiated.

7. Rules Pertaining to the Identity of the Insurer (Section 14)

"A. The name of the actual insurer and the form number or numbers marketed shall be identified and made clear in all of its marketing methods or it shall be considered misleading and therefore prohibitied. A marketing method shall not use a trade name, or insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer and therefore be prohibited.

"B. It shall be considered misleading and therefore prohibited for a marketing method to use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to any combination of words, symbols, or physical materials used by agencies of the Federal Government or of this State, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or Federal Government."

Violation 1: The employment of the insurance group designation, National Senior Citizen Group Insurance Trust, and the employment of the symbol of the group and the group newspaper without clearly disclosing their identities and relationship to the company has the tendency to deceive.

8. Rules Pertaining to Group or Quasi-Group Implications (Section 15)

"A marketing method for a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact or it shall be considered misleading and therefore prohobited."

Violation 1: The employment of the National Senior Citizens Group Insurance Trust as a marketing method and the implication that members of the trust receive special rates, privileges and treatment are misleading and deceptive. The company employed a number of similar marketing methods without providing substantive benefits or privileges different than those afforded regular policy holders. Within the company all claims and policies are processed by the same procedures.

9. Rules Pertaining to Introduction, Initial or Special Offers (Section 16)

"A. (1) A marketing method for an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact or it shall be considered misleading and therefore prohibited. A marketing method shall not contain phrases describing an enrollment period as 'special', 'limited', or similar words or phrases when the insurer used such enrollment periods as the usual method of marketing accident and sickness insurance or it shall be considered misleading and therefore prohibited.

"(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than 6 months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period or it shall be considered misleading and therefore prohibited. The marketing method shall indicate the date by which the applicant must mail the application which shall be not less than twenty days from the date that such enrollment period is advertised for the first time. This rule applies to all marketing methods. The phrase 'any one insurer' includes all the affiliated companies of a group of insurance companies under common management or control.

"(3) This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy marketed because of special advantages available in the policy unless such is fact.

"(4) The phrase 'a particular insurance product' in Paragraph (2) of this Section means an insurance policy "which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

"B. A marketing method shall not utilize an initial premium rate which is less than that premium rate which would be charged by making a uniform pro-rating of the annual premium or it shall be considered misleading and therefore prohibited.

"C. Special awards, such as a 'safe driver' award' shall not be used in connection with the marketing of health insurance or it shall be considered misleading and therefore prohibited."

Violation 1: The marketing method implying that the policy is a special policy for trust members and that members will receive a free Medicare reference card is misleading because the policy is not designated for a particular group other than the elderly. Furthermore, the Medicare reference card is given to all enrollees regardless of the time of application.

Violation 2: The use of an enrollment period is deceptive and illusory because the company markets substantially identical policies on a regular basis. There is no discontinuation after a fixed time.

Violation 3: The employment of a substantially reduced initial premium is misleading and prohibited because it overemphasizes the value of such reduced premium.

10. Rules Pertaining to Statements About the Insurer (Section 17)

"A marketing method shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. A marketing method shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation or it shall be considered misleading and therefore prohibited."

Violation 1: Statements defining the company as "the established, nationally known specialist in insurance for folks 65 and over" and "the prestigious and respected Union Fidelity Life Insurance Company" are misleading because they create a false and unsubstantiated impression as to the relative position of the insurer in the insurance industry.

C. Regulations Promulgated in Accordance with Massachusetts General Laws Chapter 175, Section 110

1. Rules Pertaining to the Form and Content of Advertisements (Section 5)

"A. The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

"B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used."

Violation 1: The format of the advertisement emphasizing the identity of the National Senior Citizens Group Insurance Trust as a group "devoted to the insurance needs of people age 65 and over" has the tendency to mislead prospective purchasers as to the quality and purpose of the trust thereby inducing a reliance on or confidence in the suggestions or recommendations of the trust. The trust itself is completely controlled and operated by the company and is employed primarily as a marketing vehicle. The publication of the National Senior Citizen Sentinel purporting to be a publication of the trust furthers the misconception about the independent nature of the trust. The disclosure of the actual purposes of the trust and the relationship of the company is not sufficiently clear and complete to avoid deception and in fact the format promotes deception by these implications.

Violation 2: The content of the advertisement as it pertains to advantages of trust membership (such as offers of free gifts, low group rates and receipt of the trust publication) is not sufficiently clear and complete to avoid deception. Aside from misconception about the purpose of the trust, there are no substantial benefits accruing to trust members which could not be obtained by non-trust members.

Violation 3: The format of the advertisement is not sufficiently clear and complete to avoid deception because it fails to adequately disclose the limitations, exclusions and reductions which are included in the policy. The advertisement makes references such as "covered" hospitals and eligible hospital charges and utilizes terms and definitions derived from the Medicare law. The meaning of these words and phrases is clear only by implication and familiarity with insurance terminology.

Violation 4: Guaranties of coverage for life and no increase in premium are deceptive because they fail to disclose that the company can terminate coverage on sixty days' notice under the provisions of the master policy. They also omit sufficiently clear references to the $50,000 maximum payable under the policy.

Violation 5: The use of the gold seal on which is emblazoned the name of the trust and the words "official", "Pennsylvania" and "Seal" has the capacity and tendency to mislead and deceive because it permits or promotes the impression that the trust has been sanctioned or approved by the Commonwealth of Pennsylvania.

Violation 6: The statement "This Medicare reference chart shows how the National Senior Citizen Group Insurance Trust works hand in hand with Medicare" is not sufficiently complete to avoid deception and has the capacity to mislead because it fails to include complete statements as to expenses not covered by the plan or Medicare.

Violation 7: The statement "It's a Fact" followed by four statements as to the quality of the plan is deceptive and has the capacity to mislead because it fails to disclose sufficiently the circumstances under which the four statements are invalid.

Violation 8: The section entitled "YOUR Questions Answered" is incomplete and deceptive because it fails to disclose limitations and exceptions and contains answers which are inconsistent with coverage. The answer to question 4 implies that doctors' bills are covered althoug apparently this is not always the case. The answer to question 3 fails to explain the time differences relative to enrollment date, the date of insurance certificate arrival and effective date. It is unclear as to the order of the dates and therefore unclear as to the date coverage commences. The answer to question 5 is incomplete and unclear because it fails to disclose fully and adequately policy exclusions. In order to adequately explain exclusions it would be necessary to define fully the benefits available under the various Medicare plans.

Violation 9: The statements concerning the consequences of showing a National Senior Citizen Group Insurance Trust membership card to a doctor or hospital are deceptive and misleading. First, advantages of low group rates are insubstantial. Second, the trust was not created "to select insurance plans." It is more accurate to say the trust was created to sell insurance plans.

Violation 10: The brochure and accompanying letter fail to include factual information regarding actual hospital and medical costs which may be incurred and courses of treatment covered by the plan so as to provide prospective policy holders with the meaningful opportunity to evaluate the adequacy of benefits and coverage available through the plan. This omission, accompanied by positive statements as to the sufficiency of the plan, gives the advertisement the capacity to mislead.

2. Rules Pertaining to Advertisements of Benefits Payable, Losses Covered or Premiums Payable (Section 6)

"A. Deceptive Words, Phrases or Illustrations Prohibited

"(1) No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium is the purchaser is not satisfied, does not remedy misleading statements.

"(2) No advertisement shall contain or use words or phrases such as, 'all'; 'full'; 'complete'; 'comprehensive'; 'unlimited'; 'up to'; 'as high as'; 'this policy will help fill some of the gaps that Medicare and your present insurance leave out'; 'this policy will help to replace your income' (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

"(3) An advertisement shall not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as, describing a waiting period as a 'benefit builder', or stating 'even pre-existing conditions are covered after two years.' Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

"(4) No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use the words or phrases such as 'tax free'; 'extra cash'; 'extra income';

"'extra pay'; or substantially similar words or phrases because such words and phrases have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

"(5) No advertisement of a hospital or other similar facility confineemnt benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number fo days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

"(6) No advertisement of a policy covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

"(7) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following: 'THIS IS A LIMITED POLICY'; 'THIS IS A CANCER ONLY POLICY'; 'THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY'.

"(8) An advertisement of a direct response insurance product shall not imply that because 'no insurance agent will call and no commissions will be paid to agents' that it is 'a low cost plan,' or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product.

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"B. Exceptions, Reductions and Limitations

"(1) When an advertisement refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

"(2) When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date of a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

"(3) An advertisement shall not use the words 'only'; 'just'; 'merely'; 'minimum'; or similar words or phrases to describe the applicability of any exceptions and reductions, such as: 'This policy is subject to the following minimum exceptions and reductions.'

"C. Pre-Existing Conditions

"(1) An advertisement which is subject to the requirements of Section 6B shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The use of the term 'pre-existing condition' without an appropriate definition or description shall not be used.

"(2) When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or "payment of a claim thereunder. This rule prohibits the use of the phrase 'no medical examination required' and phrases of similar import, but does not prohibit explaining 'automatic issue.' If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required.

"(3) When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question or statement which reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question or statement substantially as follows:

"Do you understand that this policy will not pay benefits during the first __ year(s) after the issue date for a disease or physical condition which you now have or have had in the past? YES

"Or substantially the following statement:

I understand that the policy applied for will not pay benefits for any loss incurred during the first)) year(s) after the issue date on account of disease or physical condition which I now have or have had in the past."

Violation 1: The omission of a clear statement disclosing the relationship between the company and the trust and the use of statements about and references to the trust as providing benefits to its members have the effect of misleading and deceiving prospective purchasers as to the nature and extent of policy benefits.

Violation 2: The reference to low group rates has the capacity to mislead prospective purchasers as to the nature of premiums payable because the rates offered are not substantially different from rates offered on other similar company plans.

Violation 3: Statements such as "Pays all in hospital deductibles you normally pay yourself", "We pay you 100% of all eligible hospital charges", "the threat of huge uncovered hospital bills is one of the last big money worries over you" and "the benefits will be yours to spend as you see fit" exaggerate the benefits beyond the terms of the policy because they omit relevant information as to actual costs, reductions, exclusions and limitations.

Violation 4: The statements "we even pay for a private room if approved by Medicare", "in fact, even if you're confined in a hospital that doesn't participate in the Medicare program the... trust still pays benefits to you" and similar statements exaggerate the benefits beyond the terms of the policy and are statements of limitations stated in positive terms.

Violation 5: The statement "We pay you 100% of all eligible hospital charges up to $144 a day up to $50,000" and similar statements of a limitation worded in a positive manner imply that it is a benefit.

Violation 6: The failure to disclose the exceptions, reductions and limitations affecting the basic provisions of the policy, together with the statements regarding the benefits payable under and the costs of the policy give the advertisement the capacity to mislead.

Violation 7: The brochure fails to adequately disclose the effective date of the commencement of coverage while implying coverage is immediate upon enrollment.

Violation 8: The clause pertaining to pre-existing conditions misstates the exclusion for said conditions because it implies that any sickness or injury evident prior to the effective date of the policy is not covered regardless of the time in the policy holder's life when said pre-existing condition occurred.

Violation 9: The application, designated enrollment form, fails to provide an adequate acknowledgment from the applicant of the exclusions of pre-existing conditions because it implies that only conditions treated during the 60 days immediately prior to the application are excluded.

3. Rules Pertaining to the Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination (Section 7)

   "When an advertisement refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions."

Violation 1: The terms pertaining to renewability and termination are minimized anc rendered obscure because the terms for cancellation under the master policy are not disclosed.

4. Rules Pertaining to Testimonial or Endorsement by Third Parties (Section 8)

"A. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement is subject to all the provisions of these rules.

"B. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: 'Paid Endorsement.' This rule does not require disclosure of union 'scale' wages required by union rules if the payment is actually for such 'scale' for TV or radio performances. The payment of substantial amounts, directly or indirectly, for 'travel and entertainment' for filming or recording of TV or radio advertisements remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation.

"C. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any individual group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsment or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement.

"D. When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time."

Violation 1: The use of the National Senior Citizens Group Insurance Trust as a marketing vehicle without a full disclosure of the extent of the relationship between the trust and the company and without disclosure of the fact that the trust is formed, controlled and directed by the company is deceptive and misleading.

Violation 2: The use of a gold seal with the name of the trust on it and the words "official","Pennsylvania" and "Seal" implies endorsement or approval by the Commonwealth of Pennsylvania.

5. Rules Pertaining to the Use of Statistics (Section 9)

"A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

"B. An advertisement shall not represent or imply that claim settlements by the insurer are 'liberal' or 'generous' or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

"C. The source of any statistics used in an advertisement shall be identified in such advertisement."

Violation 1: The statement that "most Medicare claims processed within 5 working days" and the statement concerning the "Instant" policy holder service are not accurately reflective of actual company claims settlement procedures and are unsubstantiated.

Violation 2: The source of the statistics which cite the occurrence of Medicare increases and the increase in costs to 25 million Americans on Medicare are not identified.

Violation 3: The statement that many folks would be only too glad to pay $10.00/month for a Medicare supplement like this is irrelevant. Furthermore, the source of such statement is not disclosed.

6. Rules Pertaining to the Identity of the Insurer (Section 13)

> "A. The name of the actual insurer and the form number or numbers advertised shall be identified and made clear in all of its advertisements. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.
>
> "B. No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols, or physical materials used by agencies of the federal government or of this State, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government."

Violation 1: The identity of the actual insurer and the relationship of said insurer to the trust are not sufficiently disclosed in such a way to avoid misleading the policy holder. Prospective policy holders are led to believe they are communicating with the trust when in fact all communications are with the company.

Violation 2: The use of the gold official seal tends to confuse or mislead prospective insureds into believing the solicitation is in some manner associated with the Commonwealth of Pennsylvania.

7. Rules Pertaining to Group or Quasi-Group Implications (Section 14)

> "An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact."

Violation 1: The advertisement states and implies that membership in the trust will enable them to enjoy special rates and underwriting privileges when such is not the fact.

8. Rules Pertaining to Introductory, Initial or Special Offers (Section 15)

"A. (1) An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as 'special', 'limited', or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising accident and sickness insurance.

"(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than 6 months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application which shall be not less than ten days and not more than forty days from the date that such enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the General Laws for group, blanket or franchise insurance. The phrase 'any one insurer' includes all the affiliated companies of a group of insurance companies under common management or control.

"(3) This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

"(4) The phrase 'a particular insurance product' in Paragraph (2) of this Section means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

"B. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

"C. Special awards, such as a 'safe drivers' award' shall not be used in connection with advertisement of accident or accident and sickness insurnace."

Violation 1: The advertisement implies that the enrollment in the trust is for a limited time only and that substantial benefits will be lost if the enrollment form is not submitted by a specified date. Such is not the case.

Violation 2: The enrollment period offered is less than 6 months from the previous offering of this plan and extends more than forty days from the date on which the plan is first offered. The use of enrollment periods by the company has the tendency to mislead because the plan, in substantially identical form, is offered throughout the year.

Violation 3: The advertisement offers a reduced initial premium of $1.00 in a manner which overemphasizes the value of the reduced premium because it is displayed more prominently and more frequently than the regular premium.

9. Rules Pertaining to Statements About an Insurer (Section 16)

> "An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation."

Violation 1: Statements that the company "is the established, nationwide known specialist in insurance for folks 65 and over" and that company is "prestigeous and respected" and has pioneered Instant Policyowner Service is by implication and in fact misleading and unsubstantiated.

D. Rules and Regulations Promulgated Pursuant to Massachusetts General Laws Chapter 93A, Section 2 for Determining Whether Conduct, Terminology and Representations Involve Unfair Methods of Competition or Unfair and Deceptive Acts and Practices

1. Regulation I.A. Pertaining to False Advertising

> "A. No advertisement containing an offer to sell a product shall be made when the offer is not a bona fide effort to sell the advertised product."

Violation 1: The promotional efforts to encourage membership in the trust is false and deceptive because the membership effort is, in fact, secondary to the effort to sell insurance.

2. Regulation IV.A. and B. Pertaining to General Misrepresentations

> "A. No claim or representation shall be made by any means concerning a product which directly, or by implication, or by failure to adequately disclose additional relevant information, has the capacity or tendency or effect of deceiving buyers or prospective buyers in any material respect. This prohibition includes, but is not limited to, representations or claims relating to the construction, durability, reliability, manner or time of performance, safety, strength, condition, or life expectancy of such product, or financing relating to such product, or the utility of such product or any part thereof, or the ease with which such product may be operated, repaired, or maintained or the benefit to be derived from the use thereof.

> "B. No advertisement shall be used which would mislead or tend to mislead buyers or prospective buyers, through pictorial representations or in any other manner, as to the product being offered for sale. Where price is featured in advertising, any picture or depiction utilized in connection therewith, shall clearly indicate the exact product being offered for sale at the advertised price."

Violation 1: Claims and representations concerning the advantages and purposes of the trust accompanied by the failure to adequately disclose the relationship of the trust to the company have the tendency and effect of deceiving the prospective purchaser in a material respect. By encouraging reliance upon trust expertise in the selection of insurance, purchasers are induced to act without sufficient scrutiny of the product and the trust, and are thus misled as to benefits to be derived from trust enrollment.

Violation 2: The promotion of enrollment in the trust as a necessary step to obtaining insurance coverage under the plan misleads the purchaser.

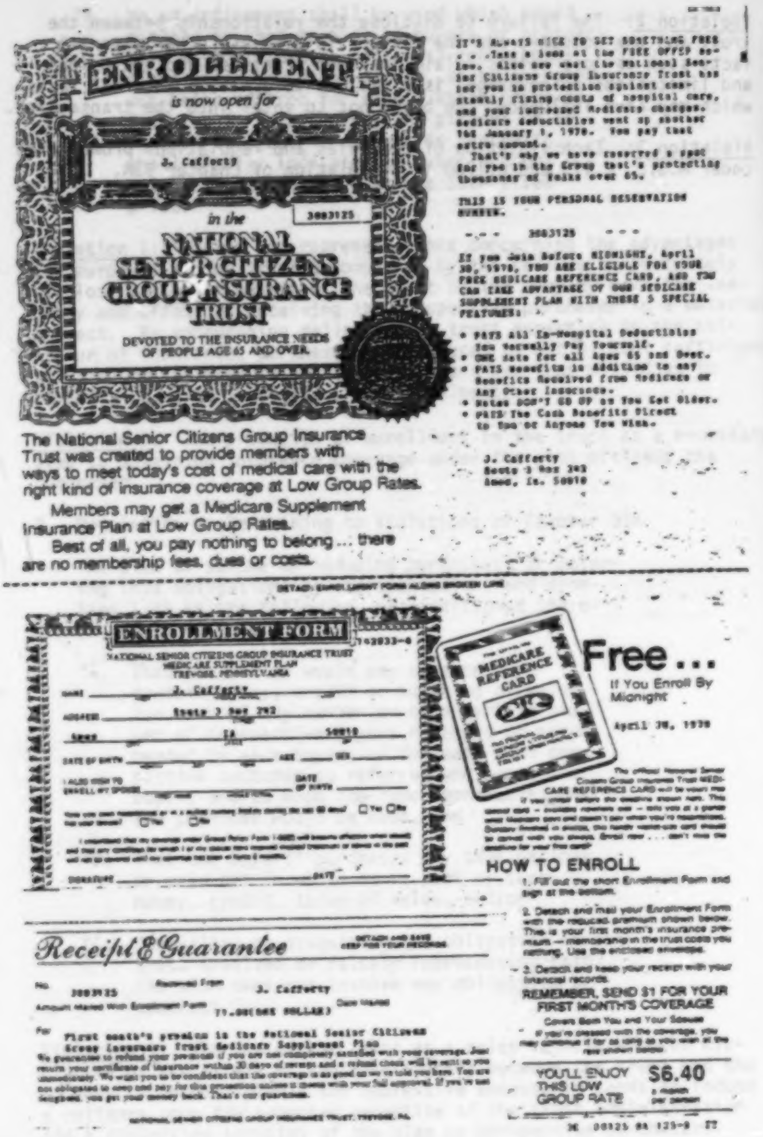
3. Regulation V. Pertaining to Violations of Chapter 93A

> "No plan or scheme of inducing purchases, or entering into obligations by representations and promises such as the following, or conditioned thereon, shall be used:
>
> "A. That the seller would pay to each buyer certain money, credit or anything of value for each of any number or of a certain number of prospective buyers referred or recommended by each buyer, or for each such prospective customer so referred who becomes a buyer, and to whom the same representations and promises would be made, and
>
> "B. That the buyers' purchases may thus be free or paid off in whole or in part by such money, credit, thing of value, and/or
>
> "C. Concealing or disguising the obligation or contract involved or falsely representing that the plan does not involve any obligation or contract."

Violation 1: The use of the trust as a sales vehicle without disclosure of the extent of the relationship between the trust and the company is unconscionable and oppressive because it tends to induce a reliance upon the supposed expertise of the trust administration and a diminished scrutiny of the plan by prospective purchasers.

Violation 2: The failure to disclose the relationship between the trust and the company, and the failure to disclose other material facts such as loss ratios, claims payment practices and exclusions and limitations to coverage, is a failure to disclose material facts which may have influenced the buyer not to enter into the transaction.

Violation 3: Each violation of the rules and regulations promulgated under M.G.L. c.175 and c.176D is a violation of Chapter 93A.



ENROLLMENT

is now open for

J. Cafferty

in the

3083125

NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST

DEVOTED TO THE INSURANCE NEEDS OF PEOPLE AGE 65 AND OVER.

The National Senior Citizens Group Insurance Trust was created to provide members with ways to meet today's cost of medical care with the right kind of insurance coverage at Low Group Rates.

Members may get a Medicare Supplement Insurance Plan at Low Group Rates.

Best of all, you pay nothing to belong ... there are no membership fees, dues or costs.

IT'S ALWAYS NICE TO GET SOMETHING FREE . . . Take a look at the FREE OFFER below. Also see what the National Senior Citizens Group Insurance Trust has for you in protection against constantly rising costs of hospital care, and your increased Medicare charges. Medicare deductibles went up another [illegible] January 1, 1978. You pay that extra amount.

That's why we have reserved a spot for you in the Group that's protecting thousands of folks over 65.

THIS IS YOUR PERSONAL RESERVATION NUMBER.

3083125

If you Join Before MIDNIGHT, April 30, 1978, YOU ARE ELIGIBLE FOR YOUR FREE MEDICARE REFERENCE CARD, AND YOU CAN TAKE ADVANTAGE OF OUR MEDICARE SUPPLEMENT PLAN WITH THESE 5 SPECIAL FEATURES:

- PAYS All In-Hospital Deductibles You Normally Pay Yourself.
- ONE Rate for all Ages 65 and Over.
- PAYS Benefits in Addition to any Benefits Received from Medicare or Any Other Insurance.
- Rates DON'T GO UP as You Get Older.
- PAYS The Cash Benefits Direct to You or Anyone You Wish.

J. Cafferty
Route 3 Box 293
Ames, Ia. 50010

DETACH ENROLLMENT FORM ALONG BROKEN LINE

ENROLLMENT FORM

742033-0

NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST
MEDICARE SUPPLEMENT PLAN
TREVOSE, PENNSYLVANIA

NAME J. Cafferty

ADDRESS Route 3 Box 293

Ames IA 50010

DATE OF BIRTH ______ AGE ______ SEX ______

I ALSO WISH TO ENROLL MY SPOUSE ______ DATE OF BIRTH ______

[illegible] ☐ Yes ☐ No

[illegible] ☐ Yes ☐ No

[illegible]

SIGNATURE ______ DATE ______

MEDICARE REFERENCE CARD

Free . . .

If You Enroll By Midnight

April 30, 1978

The official National Senior Citizens Group Insurance Trust MEDICARE REFERENCE CARD [illegible]

HOW TO ENROLL

1. Fill out the short Enrollment Form and sign at the bottom.
2. Detach and mail your Enrollment Form with the reduced premium shown below. This is your first month's insurance premium — membership in the trust costs you nothing. Use the enclosed envelope.
3. Detach and keep your receipt with your financial records.

REMEMBER, SEND $1 FOR YOUR FIRST MONTH'S COVERAGE

Covers Both You and Your Spouse

If you're pleased with the coverage, you may continue it for as long as you wish at the rate shown below.

YOU'LL ENJOY THIS LOW GROUP RATE $6.40 a month per person

Receipt & Guarantee

DETACH AND SAVE
KEEP FOR YOUR RECORDS

No. 3083125

Received From J. Cafferty

Amount Mailed With Enrollment Form $1.00(ONE DOLLAR)

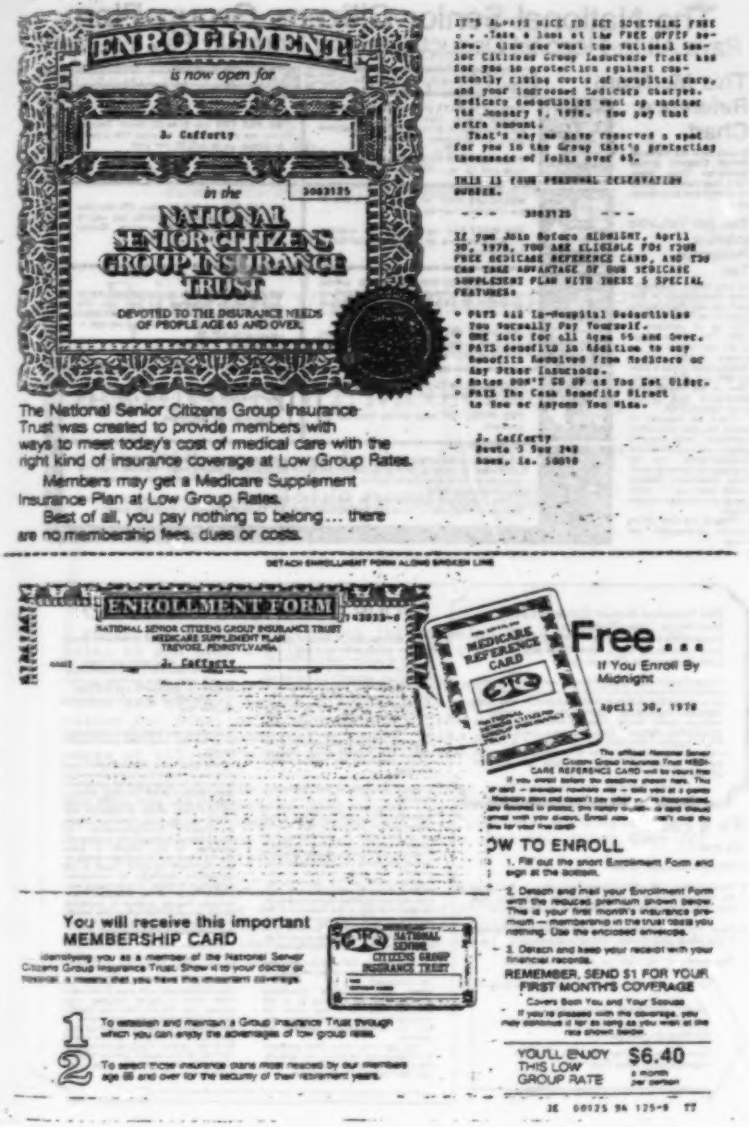
Date Mailed

For First month's premium in the National Senior Citizens Group Insurance Trust Medicare Supplement Plan

We guarantee to refund your premium if you are not completely satisfied with your coverage. Just return your certificate of insurance within 30 days of receipt and a refund check will be sent to you immediately. We want you to be confident that the coverage is as good as we've told you here. You are not obligated to keep and pay for this protection unless it meets with your full approval. If you're not delighted, you get your money back. That's our guarantee.

NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST, TREVOSE, PA.

36 08125 88 125-0 77



ENROLLMENT

is now open for

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in the

3003125

NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST

DEVOTED TO THE INSURANCE NEEDS OF PEOPLE AGE 65 AND OVER.

The National Senior Citizens Group Insurance Trust was created to provide members with ways to meet today's cost of medical care with the right kind of insurance coverage at Low Group Rates.

Members may get a Medicare Supplement Insurance Plan at Low Group Rates.

Best of all, you pay nothing to belong… there are no membership fees, dues or costs.

IT'S ALWAYS NICE TO GET SOMETHING FREE . . . Take a look at the FREE OFFER below. Also see what the National Senior Citizens Group Insurance Trust has for you in protection against constantly rising costs of hospital care, and your increased Medicare charges. Medicare deductibles went up another 16% January 1, 1978. You pay that extra amount.

That's why we have reserved a spot for you in the Group that's protecting thousands of folks over 65.

THIS IS YOUR PERSONAL RESERVATION NUMBER.

--- 3003125 ---

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- PAYS All In-Hospital Deductibles You Normally Pay Yourself.
- ONE Rate for all Ages 65 and Over.
- PAYS Benefits in Addition to any Benefits Received from Medicare or Any Other Insurance.
- Rates DON'T GO UP as You Get Older.
- PAYS The Cash Benefits Direct to You or Anyone You Wish.

J. Cafferty
Route 3 Box 248
Ames, Ia. 50010

DETACH ENROLLMENT FORM ALONG BROKEN LINE

ENROLLMENT FORM

NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST
MEDICARE SUPPLEMENT PLAN
TREVOSE, PENNSYLVANIA

NAME J. Cafferty

MEDICARE REFERENCE CARD

Free…

If You Enroll By Midnight

April 30, 1978

The official National Senior Citizens Group Insurance Trust MEDICARE REFERENCE CARD will be yours free if you enroll before the deadline shown here.

OW TO ENROLL

1. Fill out the short Enrollment Form and sign at the bottom.
2. Detach and mail your Enrollment Form with the reduced premium shown below. This is your first month's insurance premium — membership in the trust costs you nothing. Use the enclosed envelope.
3. Detach and keep your receipt with your financial records.

REMEMBER, SEND $1 FOR YOUR FIRST MONTH'S COVERAGE

Covers Both You and Your Spouse

If you're pleased with the coverage, you may continue it for as long as you wish at the rate shown below.

YOU'LL ENJOY THIS LOW GROUP RATE $6.40 a month per person

You will receive this important MEMBERSHIP CARD

identifying you as a member of the National Senior Citizens Group Insurance Trust. Show it to your doctor or hospital; it means that you have this important coverage.

NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST

1 To establish and maintain a Group Insurance Trust through which you can enjoy the advantages of low group rates.

2 To select those insurance plans most needed by our members age 65 and over for the security of their retirement years.

3E 00125 9A 125-9 TT

The National Senior Citizens Group Plan

Pays All In-Hospital Deductibles You Normally Pay Yourself

This Medicare Reference Chart

Shows how the National Senior Citizens Group Insurance Trust Medicare Supplement works hand-in-hand with Medicare.

You get Valuable Inflation Protection, Too . . .

As you know, the Medicare Deductibles — the part you pay for hospital care — went up another 16% as of January 1, 1978. This 16% increase is on top of the big increase of last year — raising your costs a total of 38% in just two years! This is the [illegible] time Medicare has raised your Deductibles.

You'll be pleased to know that our insurance company, ever since it began issuing Medicare Supplements, has increased its benefits each time Medicare Deductibles went up . . . with never an increase in premium.

This is the kind of inflation protection we need.

	WHAT IN-HOSPITAL MEDICARE PAYS AND WHAT YOU MUST PAY	WHAT THIS SUPPLEMENT PAYS YOU
DAYS 1-60 OF BENEFIT PERIOD*	**MEDICARE PAYS** all covered hospital expenses (room, board, operating room, etc.) except the $144.00 Initial Deductible and the first 3 pints of blood. **YOU MUST PAY** the $144.00 Initial Deductible and for your first 3 pints of blood.	**WE PAY YOU** the $144.00 Initial Deductible, we also pay you for your first 3 pints of blood, up to $35.00 per pint.
DAYS 61-90 OF BENEFIT PERIOD	**MEDICARE PAYS** all but $36.00 a day of the hospital charges. **YOU MUST PAY** the $36.00 a day, totaling $1,080.00 for the entire 30-day period of hospitalization.	**WE PAY YOU** the $36.00 a day. We pay you this amount for every covered day you're hospitalized during this entire 30-day period, a total of $1,080.00.
DAYS 91-150 OF BENEFIT PERIOD	**MEDICARE COVERAGE ENDS** unless you use your Lifetime Reserve (a back-up period of 60 days coverage you can use only once.) **YOU MUST PAY** $72.00 a day while using up your Lifetime Reserve . . . totaling $4,320.00 for the entire 60-day period.	**WE PAY YOU** $72.00 a day while you use up your Lifetime Reserve. We pay you this amount every covered day you're hospitalized during the entire 60-day period — totaling $4,320.00.
DAYS 151 AND AFTER	**MEDICARE PAYS NOTHING** — your hospital benefits run out. **YOU MUST PAY** your entire hospital bill yourself.	**WE PAY YOU** 100% of all your eligible hospital charges up to $144.00 a day, up to $50,000.00. We even pay for a private room if approved by Medicare.

*Medicare Supplement Benefit Period begins with the first day you are hospitalized. It continues for as long as you're confined and for 60 days after you've been released from the hospital or Extended Care Facility. You enter a new benefit period immediately the next time you're hospitalized.

This Medicare Supplement is not connected with the U.S. Government or Federal Medicare Program. It pays the deductibles that the Federal Medicare Program doesn't.

The National Senior Citizens Group Insurance Trust Medicare Supplement Is Underwritten And Administered By Union Fidelity Life Insurance Company

Union Fidelity is the established, nationally known specialist in insurance for folks 65 and over. Their service is among the very best in the industry — with most Medicare Supplement claims processed within 3 working days. Union Fidelity pioneered "Instant Policyowner Service." Just dial their special TOLL-FREE number 1-800-523-5788 (continental U.S. ONLY) and a trained specialist will be on the line to give you immediate assistance (Penna. residents, call 322-2000 COLLECT).

It's a Fact

Our Plan . . .

- Offers One Rate To All
- Guarantees Your Coverage For Life . . . As Long As You Pay Your Premiums When They Are Due And The Master Policy Remains In Force.
- Pays You In Addition To Any Benefits Received From Medicare or Any Other Insurance
- Our Rates do Not Go Up as You Get Older

Act Now! **Fill Out The Enrollment Form On The Other Side . . . No Risk Or Obligation!**

Remember — There Are No Dues or Membership Fees Ever!

YOUR QUESTIONS ANSWERED

1. Can the insurance company cancel my coverage or raise my rates?

As long as you pay your premiums on time and continue as a member, NO INDIVIDUAL MEMBER CAN EVER BE CANCELLED as long as you have benefits remaining. What's more, the insurance company can never raise your individual rates . . . this is true even if you have many claims or your health changes. Premiums can be changed or renewal denied only if the same action is taken on all insureds [illegible] under the Master Policy [illegible].

2. Will I get paid in any hospital I choose?

Any hospital that is recognized by Medicare Law 1-1966 Title XVIII, is also recognized by us, too. In fact, even if you're confined in a hospital that doesn't participate in the Medicare Program, the National Senior Citizens Group Insurance Trust Medicare Supplement still pays benefits to you. Facilities such as T.B. Sanitariums, drug or alcoholic clinics are not covered, nor are facilities where there is no obligation to pay in the absence of insurance, mental institutions, nursing homes, convalescent or extended care facilities. Federal Medicare does cover confinement in a mental institution.

3. Suppose I no sooner get my insurance and I land in the hospital . . . am I covered?

When your Insurance Certificate arrives it will be in force as of the effective date. So if you enter the hospital for a covered condition, you will be immediately eligible for benefits.

You just never know when accident or illness will strike you or your spouse. We've seen it happen to people the very day their coverage commences.

4. Does the plan pay all benefits direct to me?

Yes, indeed. All checks are made out directly to you. For your convenience, we will even make payment to your hospital or doctors if you request it. The benefits will be yours to spend as you see fit.

5. All insurance plans have exclusions. What are the things this plan doesn't cover?

1) PRE-EXISTING CONDITIONS (any sickness or injury medically advised or treated or for which distinct symptoms were evident prior to your policy's effective date) UNTIL AFTER YOUR POLICY HAS BEEN IN FORCE SIX MONTHS. 2) Loss covered under Workmen's Compensation or Occupational Disease Law, or services rendered by any federal or state agency when you do not have to pay or any treatment rendered which is not considered necessary by competent medical authorities. 3) Loss due to war, acts of war; mental disorders; self-inflicted injuries; alcohol or narcotics unless administered under the advice of a physician; custodial care. 4) Does not supplement Medicare Part B.

6. Do I have to send in a full first premium to apply for coverage?

No. YOUR INITIAL PREMIUM IS $1. Mail this amount with your Enrollment Form even if you're including your spouse, too. We will mail your Certificate of Insurance to your home. If you're satisfied, you may continue your coverage at the regular monthly rate of $5.40 per person. If you decide against the Plan for any reason, simply return it within 30 days and you'll get your money back.

Licensed — [illegible] and [illegible] but does not imply endorsement by the states

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NATIONAL SENIOR CITIZENS
GROUP INSURANCE TRUST

NATIONAL EXECUTIVE OFFICES • TREVOSE, PENNSYLVANIA 19047

...Bringing you what may be the best news for folks 65 and over since Medicare began!

*Plus an exclusive FREE GIFT available nowhere else!

Dear Senior Citizen:

There are a lot of different things being done today to give folks 65 and over a helping hand. And it's about time.

Many stores now offer you special discount prices. And in many towns and cities, senior citizens ride public transportation either for free, or at a fraction of the cost. There's a lot more, too. Unfortunately, a lot of folks, like yourself, aren't aware of all that's now available to you.

A perfect example is that you have been selected to take advantage of the benefits offered by the NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST. And best of all, you pay nothing to belong...not now, not ever! Let me explain what the Trust does for you, absolutely free of charge...

First, the National Senior Citizens Group Insurance Trust helps answer those difficult questions about the right kind of insurance protection you should have at this time in your life. Second, and most important of all, we offer you Group Insurance Protection at Low Group Rates.

over...

This is a Medicare Supplement that begins to work for you on the first day you enter the hospital. Right off the bat, it covers the $144.00 Initial Medicare Deductible...an expense you have to pay even if you spend only one day in the hospital. The plan goes on from there to pay you all the rest of your Hospital Medicare Deductibles, which could represent over $5,500.00, an amount you would normally have to pay yourself.

What happens when Medicare stops paying your hospital bills altogether? What kind of help does the National Senior Citizens Group Insurance Trust Plan give you then? It pays 100% of all your eligible expenses up to $144.00 per day. The plan completely takes over and pays all your hospital bills which Medicare was paying. And keeps on paying right up to the lifetime maximum of $50,000.00. This Plan will even pay for a private room if okayed by Medicare.

Even if you are age 65 or over but not eligible for Medicare, you need not worry. You are still eligible for this Supplement and all the listed benefits, just as though you had Medicare.

All the benefits are paid direct to you; or if it is more convenient for you, we will mail it directly to the hospital or anyone you wish.

Now, there's no longer any reason why you should have to sacrifice your own savings to pay Medicare Deductibles. As a member of the National Senior Citizens Group Insurance Trust, you are able to go to the hospital and just concentrate on getting better.

Many folks would be only too glad to pay $10.00 a month for a Medicare Supplement like this. But you don't even have to pay that much. Under our Group Rate, members pay $6.40 a month per person regardless of age. And for the first month, you pay a reduced premium of $1.00. Affordable? You bet!

- To enroll, just return the enclosed Enrollment Form...Include the reduced first month's Medicare Supplement premium. That's all there is to it.
- You'll receive your Certificate of Insurance by return mail to examine. If you're satisfied, you may stay with the Plan at our LOW GROUP RATES for as long as you wish. If you're not, you'll get your money back!

Should you decide against the Medicare Supplement Plan for any reason, just send it back within 30 days and your premium will be refunded immediately. No questions asked. No cost to you!

Why not pick up a pen right now and fill out the enclosed Enrollment Form...then mail it in right away. You'd be making a mistake if you don't at least take a close look at this Important Plan.

AN EXCLUSIVE FREE GIFT, TOO! When you enroll in the National Senior Citizens Group Insurance Trust Plan, you will also receive your free personal Medicare Reference Card. Durably finished in plastic, this handy wallet-sized card tells you at a glance the expenses you are required to pay when you're hospitalized under Medicare.

This valuable card is available nowhere else. It has been designed exclusively for our new members, and will be yours to keep - FREE. It's yours for the asking, even if you don't want the insurance. But don't delay: you must reply before the deadline date shown on your enrollment certificate.

In the meantime, while you're waiting for your Insurance Certificate and Medicare Reference Card to arrive in the mail, take a close look at the special brochure enclosed for you. It contains the latest 1978 Medicare information, and tells you exactly how the National Senior Citizens Group Insurance Trust Supplement works hand-in-hand with Medicare. You'll also find the exclusions and renewal provisions clearly spelled out for you.

The threat of huge uncovered hospital bills is one of the last big money worries over you. You've worked too hard and too long not to give yourself the protection and security you deserve. Mail your Enrollment Form in right now. It's in your best interest to take a closer look. There's no obligation.

Sincerely,

John V. Cassidy

John V. Cassidy
For The National Senior Citizens
Group Insurance Trust

P.S. You'll be very pleased to know that the insurance company for the Trust is the prestigious and respected Union Fidelity Life Insurance Company. These are the insurance people who pioneered "Instant Policyowner Service" and the toll-free telephone "Hotline". Union Fidelity invites you to sample their fast, friendly service. If you have any questions about the plan, you can call (continental U.S. only) this TOLL-FREE number right now: 1-800-523-5758 (Pennsylvania residents call 322-3000 COLLECT).

UNDERWRITTEN AND ADMINISTERED BY: UNION FIDELITY LIFE INSURANCE CO.

RIGHT NOW ENROLLMENT IS OPEN TO YOU IN THE NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST MEDICARE SUPPLEMENT PLAN!

Medicare is the greatest thing ever done for folks 65 and over. As good as Medicare is, it still doesn't pay for everything when you're hospitalized. It can cost you anywhere from $144.00 to over $5,500.00 during a Benefit Period. But once you're a covered member of the National Senior Citizens Group Insurance Trust, you don't have to worry about these big expenses any longer.

Before I list all the benefits which our Medicare Supplement pays, let me first give you an updated list of the exact Medicare Deductibles you have to pay. These amounts went up 16% Jan. 1, 1978 and comes on top of the big increase of last year...raising your costs a total of 38% in the past two years. Here are the amounts:

THESE AMOUNTS REFLECT THE 16% INCREASE IN MEDICARE DEDUCTIBLES EFFECTIVE JAN. 1, 1978

YOU PAY $144.00 even if you spend only one day in the hospital.

YOU PAY $36.00 a day from your 61st to 90th day.

YOU PAY $72.00 a day from your 91st to 150th day.

YOU PAY Your entire hospital bill after your 150th day.

This means anytime you are hospitalized at the start of a Medicare Benefit Period, you have to pay charges ranging anywhere from $144.00 to $5,500.00 or more out of your own pocket.

Here's the good news...the National Senior Citizens Group Trust Medicare Supplement will pay you all the Medicare Hospital Deductibles listed above...plus, it will pay you 100% of your total eligible hospital bill when Medicare stops paying!

Here's a more complete list of the benefits our plan pays you.

AMOUNTS INCLUDE 16% INCREASE IN OUR BENEFITS TO MEET YOUR HIGHER COSTS. NO INCREASE IN PREMIUMS

PAYS YOU the $144.00 Initial Medicare Deductible.

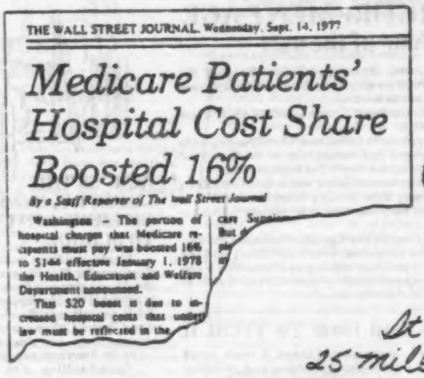
PAYS YOU the expenses for your first 3 pints of blood (up to $35.00 per pint).

PAYS YOU the $36.00 a day Deductible.

PAYS YOU the $72.00 a day Deductible.

PAYS YOU 100% of your total eligible Hospital bill up to $144.00 per day - to the $50,000.00 maximum - when Medicare stops paying.

It's Front Page News...



THE WALL STREET JOURNAL, Wednesday, Sept. 14, 1977

Medicare Patients' Hospital Cost Share Boosted 16%

By a Staff Reporter of The Wall Street Journal

Washington – The portion of hospital charges that Medicare recipients must pay was boosted 16% to $144 effective January 1, 1978 the Health, Education and Welfare Department announced.

This $20 boost is due to increased hospital costs that under law must be reflected in the

care Sup

a 16% hike in your Medicare Costs starts Jan. 1, 1978

It means the 25 million Americans on Medicare will now have to pay $770.00 more during a Benefit Period. But don't worry... our Medicare Supplement Benefits were raised automatically to meet this increase ... and at no increase in rates!

THE NATIONAL SENIOR CITIZEN SENTINEL

A PUBLICATION OF THE NATIONAL SENIOR CITIZEN GROUP INSURANCE TRUST

NO. 138

CIRCULATION 5,000,000

MANDATORY RETIREMENT AGE may one day be a thing of the past

Earlier this year, President Carter signed legislation changing the mandatory retirement age from 65 to 70 for most private industry employees and eliminating it completely for federal workers.

The bill had little opposition with the Senate's vote standing at 62-10 and the House of Representatives' at 391-6.

Senior Citizens realized a victory, but not a final one. The ultimate goal is to eliminate the mandatory retirement age completely, or as Rep. Paul Findley of Illinois put it, to " . . . correct its (the bill's) imperfections."

The same day that House and Senate committees met to settle details on the latest mandatory retirement age, Rep. Findley introduced a bill to eliminate it entirely. Although action on it this session is unlikely, he has reserved a bill number for it in 1979.

As it stands now, the new law amends the Age Discrimination in Employment Act of 1967 and gives Senior Citizens at least 5 additional working years if they so desire. It cannot stop you from retiring at 65 or earlier if you want and it does not alter 65 as the age at which most people are eligible to start receiving their maximum Social Security benefits.

SHOCK - What It Is And How To Treat It

What is "shock?" Often, after a serious accident, a person is said to "go into shock." What is this condition? Is it dangerous? And what are the first aid measures prescribed for coping with it?

Shock is a condition in which the body functions become depressed because not enough blood circulates through the body. Untreated, shock may be fatal even though the injury producing it would not result in death.

Burns, wounds or fractures may produce shock -- especially when there is bleeding. Rough handling which increases or causes hemorrhaging to recur should be particularly avoided.

Symptoms are: skin that is pale, moist and cool, vomiting, loss of alertness and thirst. A weak, rapid pulse, fast breathing and occasional deep breathing may also develop.

All seriously injured persons should be treated for shock immediately even though evidence of shock has not developed. The same measures are used for the prevention as for shock. Keep the patient lying down unless there is bleeding from the head or difficulty in breathing. In the latter case raise the head and shoulders.

Prevent the patient from losing body heat by covering lightly.

Lukewarm water may be given for thirst but should be given slowly and stopped if it produces vomiting. No alcoholic drinks or other stimulants such as coffee should be given.

continued on Page 4

Medicare deductibles, the part you pay out of your pocket, have risen 11 times in the last 12 years. Many indications point to still another increase in January 1979.

The National Senior Citizens Group Insurance Trust has announced it will raise the benefits of its *Medicare Supplement Policies* to match any increase in deductibles by Medicare. THERE WILL BE NO INCREASE IN COST TO YOU.

ACROSS THE COUNTRY, SENIOR CITIZENS RETURN TO SCHOOL.

Maybe you have not been in a classroom for 40 or 50 years, but that should not stop you from returning to school if the idea appeals to you. Adult education is flourishing and many Senior Citizens are numbered among those carrying stacks of books on American campuses.

Opportunities are endless whether you are interested in practical skills or professional training, whether you want to complete your high school diploma or your master's degree or start college for the first time.

If money is a determining factor, this is something to keep in mind. Tuition-free education may be on the way for Senior Citizens who desire to continue their schooling. Earlier this year, Rep. Claude Pepper of Florida introduced a bill which would provide such a benefit for qualified older persons. His legislation calls for federal grants to compensate colleges and universities for 50% of the tuition expenses of Senior Citizens attending classes for free.

If you are not ready to swing into full time enrollment or you are looking for less strenuous educational activities, there are still numerous opportunities available.

continued on Page 4

SENIOR CITIZENS CAN EXERCISE

You used to enjoy exercise, but now you feel push-ups and sit-ups are just a little too strenuous for you to handle. Sure, there are plenty of Senior Citizens golfing, swimming or playing tennis, but if for health reasons you cannot participate, it doesn't mean you have to sacrifice all exercise.

Though many people do not think of it, walking is exercise. It stimulates your muscles, keeps your joints flexible and helps your blood circulate. Walk only brief distances at a time and always dress in loose but warm clothing, wear comfortable shoes and never overtire. If the weather does not permit an outside jaunt, walk in your room, on the porch or through the house.

If leg cramps occur while you are walking, stop immediately. This is a warning sign of poor circulation. See your doctor; oftentimes medication can relieve this condition.

When walking is inadvisable, there are still simple exercises available that require no physical exertion.

To exercise the muscles in hands, arms, shoulders and chest, sit with fingers clenched together in front of you above your waist, pull hard, then relax. Repeat several times. For neck muscles, try slowly rotating your head.

Another good exercise for hand muscles and joints is squeezing a sponge or tennis ball. Repeat 6 or 7 times a day. For fingers, extend arms, keep fingers loose and rotate to circulate blood in your finger tips.

You may also want to exercise your feet and toes to keep the blood flowing, especially during cold weather. Sit on the edge of your bed and rotate feet. Rising up on your toes or wiggling your toes will also keep your feet flexible. Or try the bicycle act. Lie on your bed, raise your feet and pedal an imaginary bicycle.

If you still miss your early morning push-ups, you might want to try this imitation push-up. Stand 2 feet from a bathroom wall, grasp towel bar, lean forward and push back. This will bring shoulder and chest muscles into action.

If at any time you feel pain or dizziness, stop all exercises immediately.

One last suggestion — a rocking chair is a good exercise tool. It brings into use toes, feet, legs and finger muscles (if you grip the handles of the chair). Many people find that the motion creates a relaxing mood.

Now you are ready to set up a daily pattern of exercise. Keep in mind that an evening routine should be less vigorous than one in the morning. It is a good idea to check with your doctor before doing any exercises. He may have additional suggestions or know of exercises that would be more beneficial for your particular health problems.

Remember, exercise is not only good for your health, but it is an inexpensive pastime. It can turn the boredom of inactivity into a refreshing experience!

How to control those pesky mosquitoes

Mosquitoes develop usually in still water and cannot survive the wave action of open bodies of water or flowing streams. The following steps will help control nuisance mosquitoes as well as those which might transmit diseases.

Eliminate breeding sites

- Eliminate all standing water around the house if possible.
- Change water in wading pools or bird baths every week.
- Keep water from pooling on the surface of pool covers or other similar plastic coverings.
- Swimming pools if properly filtered and chlorinated will not be suitable for mosquito larvae to develop.
- Dispose of empty cans or pails, upend buckets or any other container that is left outdoors.
- Clean out clogged eavestroughs and drain flat roofs.
- Empty old tires and dispose of them.
- Do not clog drainage ditches with trash; make sure that ditches and driveway gutters drain properly.
- Empty water from stored boats.
- Empty rain barrels.
- Fill in low depressional areas to prevent standing water.

Outdoors

- Reduce the amount of vegetation through mowing weeds and grass, trimming hedges and removing unnecessary shrubbery and trees which protect the adult mosquito against sun and wind.
- Use netting over carriages when babies are left outside.

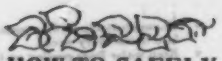
What can you do to avoid bites

- Restrict outdoor activity in the evening when mosquitoes are most active.
- Repair the holes in window or door screens and make sure the screens are tight.
- Close the damper on your fire place when not in use.

Personal Protection

- If you are working or visiting in areas where mosquitoes are abundant, wear loose protective clothing, i.e. long-sleeved shirt, light jacket, slacks and socks.
- Lighter coloured clothing is less attractive to mosquitoes than is dark clothing.
- Use common sense; mosquitoes are most active in the evening and can be bothersome in wooded areas during the day.
- Use repellents — keep them out of your eyes and mouth. Always read the label and follow instructions. Those containing higher concentrations of active ingredient usually are more effective.

Insecticides are available which may provide temporary relief. Use pesticides safely — carefully follow manufacturer's instructions and read the label.



HOW TO SAFELY MOVE YOUR HOUSE PLANTS

It's not uncommon for a plant loving family to have 30 to 40 plants, ranging in size from small to giant. It's a healthy trend in home life, but can pose a problem on moving day.

There was a time when the recommendation was to give plants away rather than to try to move them. Today persons moving wouldn't think of leaving their plants behind.

In many instances, plants can be loaded on the moving van. However, because plants may get too warm or too cold, particularly on moves of long distances, the best method may be to move them in the car.

Here is a calendar of steps to be taken in preparing plants:

Three Weeks Before Moving Day: Tell your agent if you plan to move plants in the van. Call your local Dept. of Agriculture to check on regulations for moving plants from your present state to your new location.

Any plants in clay pots should be repotted in unbreakable plastic containers. They must be big enough to hold the root system, but only large enough to hold the plant.

Two Weeks Before Moving Day: To kill any parasites that may be on the plant or in the soil, place your plants in a black plastic bag for about six hours with a bug/pest strip or a conventional flea collar. Put bag in a cool, shady area.

Moving Day: Conventional packing cartons are adaptable to moving plants. The plants should be securely anchored so they won't slip when the box is lifted. Dampen newspaper or packing paper and wrap the pot and leaves. Place pot in a box, make sure it fits snugly in the bottom. Make sure the limbs are cushioned with paper. Place dampened paper loosely around the top of the plant to further protect the leaves.

Plants should be watered normally before packing during the warm months, only slightly during the cold months.

Punch air holes in the sides of the box and fasten lid loosely. If you are moving the plants in a car avoid putting them in the car trunk, unless there is no other option, as heat or cold can cause damage.

On The Road: Be sure when you park your car that you leave a window open and park in a shaded area in the summer, the opposite in the winter.

At Your New Home: Unpack plants as quickly as possible. Remove them through the bottom of the box to avoid breaking branches. Don't overexpose your plants the first few weeks.

If you don't have space to carry plants, take cuttings. Place them in a sterile mix or put cuttings in a plastic bag with damp cotton or paper towels. They should be in good shape to take root at your new home.

SENIOR CITIZENS ON THE MOVE:

IS IT FOR YOU?

"To move or not to move?" Retirees often find themselves facing this question and each year, approximately 150,000 say "yes" and cross state lines to resettle.

Retirement provides Senior Citizens with the freedom to move — no job ties, plus leisure time to look for a house and handle all the packing and moving details. Yet on the other hand, retirement is the cause of one drawback — a reduced income, and there is no getting around it, moving is expensive. So, one important consideration to whether you stay or go, is money. Before you make your decision, give some thought to these financial aspects of the situation.

If you are thinking of moving out of state, remember, the cost of living and tax advantages vary from state to state. For example, the approximate average cost of living for a retired couple in Alabama is $5,100, while in California it is $7,000. In addition, Alabama offers a double tax exemption for persons 65 and older and for the blind and disabled. These are things you definitely should look into, and to a lesser degree, you should check out the sales tax which can range from no tax to as high as 7% as in Mississippi.

Some Americans are now considering moving abroad to enjoy their retirement years. A few popular spots include Mexico, Spain, Portugal, Costa Rica and the West Indies.

The financial advantages are obvious: fewer taxes, low rent and housekeepers and cooks available at low salaries compared to U.S. standards. Yet, you would be facing some big differences in your lifestyle. The food and water would be unfamiliar, the supply of hot water, electricity and telephones is usually less, and the availability of doctors and medical assistance is not the same abroad as in the United States. You have to weigh what is most important to you, but in this case, a simple vacation test may tell you all you need to know.

Once you have made the decision to move, whether to a different city, state or country, there is one important thing to keep in mind. If you are over 65 and contract to sell your house, you are eligible for a tax relief. This means you can save all or part of the gain from your house's sale from being taxed.

If you and your spouse jointly own the property, only one of you need be over 65. This is how it works. When the "adjusted" selling price of your house is $35,000 or less, you pay no tax on the gain. When the "adjusted" price is more than $35,000, you are still eligible for a savings based on your tax bracket. (The "adjusted" selling price is the selling price less any expenses of selling, such as legal fees, real estate fees or repair costs.) Your accountant or lawyer will be able to give you more details of how the exemption works.

"Should I move or should I stay?" This is an important question and only you can decide, but there are many sources of advice and information available to help you make the decision. Talk to friends, relatives and other retirees who have moved. Try swapping your house for a few weeks for one in the community where you are interested in settling. Contact governmental agencies, such as the Federal Housing Administration, your local Farmer's Home Administration office or your state Real Estate Commission for informative suggestions. Then make your decision.

AROUND THE HOUSE . . .

REFINISHING YOUR OLD FURNITURE

Before you decide to throw out that old coffee table, dresser, rocking chair or night stand, why not refinish it yourself! Underneath that dulled, scratched or painted furniture is a quality of wood not often found in today's market. One would have to pay a high price for the quality that can be found in your own home.

Don't think you must be a master wood finisher to do this. More and more people are furnishing their homes with furniture that they finished or refinished themselves . . . all at substantial savings! All it takes is your spare time and a little desire. You will be rewarded with the self satisfaction of working with your hands and the gratification of enhancing the beauty of natural wood. You might also be saving money in the long run by deciding not to buy that new rocker, dresser or bedroom set.

Here's a list of the basic tools you'll need:

1. paint brushes (2)
2. work gloves
3. varnish remover
4. paint thinner

5. paint scraper
6. knife
7. sand paper (med.-fine)
8. wood stain

9. varnish
10. steel wool (fine-extra fine)
11. linseed oil

First, you will need a place to work: the garage, basement, or utility room are ideal. Protect the floor with newspaper or cardboard. Wear your work clothes. Once you begin varnishing, keep the area as dust-free as possible. Open that window or garage door for ventilation.

Removing the old paint or varnish is a messy job, so if you prefer, you may decide to take the item(s) to be stripped to a furniture refinishing shop. Instruct them to dip and strip the furniture. The cost is nominal. If you go this route, start at Step 4 below.

PROCEDURE

Step 1 — PROTECT YOUR HANDS WITH WORK GLOVES when using varnish remover. Apply liberal amount of varnish remover with an old brush. Work into crevices. For larger pieces, do one area at a time. Let set until surface ripples.

Step 2 — Gently scrape off old paint or varnish with paint scraper, using a knife for hard-to-get places. If paint or varnish is not completely stripped, repeat Step 1. Paint remover makes wood soft, so be careful not to gouge the wood with your scraper.

Step 3 — Using a medium to fine grade sandpaper, smooth out nicks or splinters. (For deep gouges or holes, you can buy a wood-toned, plastic filler kit, that when melted, fills gouges and holes.)

Step 4 — Apply desired stain with a clean brush, painting with the grain, then against, finally with the grain. Depending on how dark you want the piece of furniture, let stain set, then wipe off with a soft, clean rag. Repeat this step if you desire a darker hue. Set piece of furniture aside to dry.

Step 5 — With a soft, clean brush, apply varnish, painting with, against, then finally with the grain. This type of painting stroke gets the varnish into the wood. (If working with a polyurethane varnish, you must work fairly fast and, once you've completed a section, do not go over it, as it will leave paint strokes. Also, do not shake or stir polyurethane. It causes bubbles and the brush will pick them up and spread them onto the wood. Needless to say, varnish is much easier to work with.) Set the piece aside to dry once you have applied the first coat.

Step 6 — Gently sand the piece with fine sandpaper — working with the grain. Wipe clean and repeat Step 5 at least 2 more times. (The more coats you apply, the deeper the finish.) Let dry, then polish with furniture polish or wood wax. If you stop here, you will have a gloss finish.

Step 7 — If you desire a satin finish rather than a glossy finish, do this step. Using fine or extra fine steel wool soaked in linseed oil, rub the piece of furniture — with the grain. (Some finishers use a powdered pumice and linseed oil mixture.) Rub with even pressure — not too hard or too soft. Pour additional oil on area as needed. Wipe with soft cloth. Repeat as necessary to smooth out flaws and bubbles. Polish with wax or any furniture polish.

Using these 7 basic steps will turn that old piece of "junk" into something you'll be proud to keep, admire and show your friends.

In a world of rapidly mounting automation, many people are realizing the unheralded satisfaction and therapy of working with their hands. Whether young or old, furniture refinishing is one of the most gratifying ways to help yourself, help your home and your pocketbook.

AROUND THE HOUSE . . .

Do you have a favorite recipe, hobby or hints for home improvements that you would like to share with other Senior Citizens across the country? If you do, mail your ideas along with your name and address to:

National Senior Citizens Group
Insurance Trust
National Executive Offices
Trevose, Pennsylvania 19047
Attn: Cathy Jones 16-O

We will select a few of the suggestions which we feel have the most interest to our readers to be included in each issue.

continued from page 1

SHOCK

No fluids should be given if the patient is only partly conscious or has an abdominal wound.

Don't apply hot water bottles or heating pads. Don't disturb victim by noise, manipulation or a lot of questioning.

And, call for a physician as soon as possible.

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continued from page 1

RETURNING TO SCHOOL.

Consider, for example, correspondence and extension courses offered on a wide variety of subjects by many universities across the country. Some are taught over public television stations, so you can learn at home and still earn college credits. In addition, there are commercial correspondence courses, but it is best to check with your local Better Business Bureau or Department of Consumer Affairs before enrolling to make sure you are dealing with a reputable company.

Lecture series, usually with free admission, are held at many public libraries, universities and museums. Also, you might check out your local YMCA, churches and synagogues for special adult education programs.

Go back to school? Why not? There is no time to learn like the present -- education is not just for the young anymore!

IMPORTANT NOTICE!

You now have an extra month to get your Medicare Reference Card... Absolutely Free!

Because we know that not just a few, but every Senior Citizen is affected by increasing Medicare Deductibles, and because of the overwhelming response, we have extended the Deadline Date until May 27, 1978 for our Medicare Reference Card. Our aim — to make this important offer available to as many Senior Citizens as possible. Now it's up to you to decide! Remember, when you enroll before May 27, 1978, you will receive your Exclusive Medicare Reference Card ABSOLUTELY FREE.

SO DON'T DELAY... ENROLL NOW!

EXHIBIT 6

MEDICARE SUPPLEMENT POLICY

Contents Page No.

I. Items Reviewed. 1

II. Legal Analysis. 1-8

EXHIBIT 6

Medicare Supplement Policy

I. Items Reviewed:

A. Union Fidelity Seven Star Medicare Supplement Plan
Form Number DR-1-8120-MA

Filed for approval with the Commonwealth: May 31, 1978
Approved by Commissioner of Insurance: June 8, 1978

NOTE: The policy, having been filed after December 1, 1974, is subject to the requirements of Regulation 2-74.

II. Legal Analysis

A. Regulation 2-74, as Amended by Regulation 3-75, Establishing Minimum Standards of Full and Fair Disclosure for the Form and Contents of Accident and Sickness Insurance Sold in the Commonwealth of Massachusett

1. Regulation 2-74, Section 5, Paragraph 13:

"Policies providing convalescent or extended care benedits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital."

Violation: The coverage for convalescent or extended care is conditioned upon having been hospitalized for at least 3 consecutive days which is a more restrictive standard than that set forth in the regulations. Furthermore, the use of the term "within" 14 days is ambiguous when viewed in relation to the standard of the regulation.

2. Regulation 2-74, Section 5, Paragraph 15:

"When the Medical Information Bureau is used by the insurer, the policy application or another appropriate notice shall indicate the possible use of this service as it related to medical information concerning the insured."

Violation: The application does not give adequate notice as to the use of the services of the Medical Information Bureau or other similar agency.

3. Regulation 2-74, Section 5, Paragraph 20:

"No pre-existing exclusion provision shall exclude coverage for any pre-existing condition other than for the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis. care or treatment or a condition for which medical advice or

> "treatment was in fact recommended by a physician or received from a physician within twelve months preceding the effective date of the policy. The policy provision shall explain the actual test to be used."

Violation: The clause entitled "Pre-Existing Conditions" appearing on the first page of the policy is not in accordance with the regulation. One might infer from the position of the clause that the clause is intended as a pre-existing condition esclusion. The clause itself does not provide for exclusion, nor does the "exclusion" clause elsewhere in the policy. However, assuming that it is intended to be an exclusion clause, it makes more restrictive the definition of pre-existing condition than that required by the regulation. The company policy clause permits the finding of a pre-existing condition upon a determination by a legally qualified physician that the condition probably began before the effective date of coverage and that an ordinarily prudent person would have sought diagnosis, treatment or care. First, the determination by a physician as to what an ordinarily prudent person would or should do may be different than that of a layperson. Second, the company has on its staff a medical director who is a legally qualified person within the definition of the clause and who, as part of his duties, will review medical histories of claimants on occasion. His determination of "ordinarily prudent" will be based upon his experience in his general locale. The determination should be based upon the standards of the area in which the claimant lives and should be made by a person without a financial interest in the company.

4. Regulation 2-74, Section 5, Paragraph 21:

> "No policy shall exclude coverage for a loss due to a pre-existing condition for a period greater than 12 months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical condition or prior medical care and treatment and such pre-existing condition is not specifically excluded by the terms of the policy."

Violation: In addition to the comments on pre-existing conditions set forth above, the application does not affirmatively seek a meaningful disclosure of prior illness, disease or physical condition or prior medical care or treatment. As a result, pre-existing conditions cannot be specifically excluded unless the policy and application are redrafted to insure compliance with this regulation.

5. Regulation 2-74, Section 5, Paragraph 36:

> "Indemnity policies not based on medical experience shall not contain provisions that exclude coverage because of confinement in a hospital operated by the Federal Government."

Violation: The policy is not based upon medical experience and is thus prohibited from excluding coverage because of confinement in a hospital operated by or for the Federal Government.

6. Regulation 2-74, Section 6 (B):

> "(B) 'Hospital' may be defined in relation to its status, facilities and available services or to re-reflect its accreditation by the Joint Commission on Accreditation of Hospitals.
>
> "(a) The definition of the term 'hospital' shall not be more restrictive than one requiring that the hospital
>
> "(1) be an institution operated pursuant to law, and
>
> "(2) be primarily and continuously engaged in providing or operating, either on its premise or in facilities available to the hospital and under the supervision of a staff of duly licensed physicians, medical, diagnostic and acute care facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made, and
>
> "(3) provide 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).
>
> "(b) The definition of the term 'hospital' may state that such term shall not be inclusive of
>
> "(1) convalescent homes, convalescent, rest, or nursing facilities, or
>
> "(2) facilities primarily affording custodial, educational or rehabilitory care."

Violation: The definition of "Hospital" in the policy is in violation of this regulation because it excludes facilities operated by or contracted for the United States Government and institutions used as a place for rehabilitation, the aged, drug addicts, alcoholics and mental institutions to an extent beyond the scope of the regulation. Furthermore, the definition of the policies are more restrictive with regard to the facilities required than permitted by the regulation.

7. Regulation 2-74, Section 6 (G):

> "(G) 'Nurses' may be defined so that the description of nurse may be restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words 'nurse', 'trained nurse' or 'registered nurse' are used without definition, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state."

Violation: The definition of "Nurse" in the policy is in violation of the regulation because it excludes nurses otherwise qualified who are immediately related to the policy holder.

8. Regulation 2-74, Section 14:

> "No individual accident and sickness insurance policy or contract shall be delivered or issued for delivery in this state unless the appropriate disclosure form, plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point, as prescribed in sections 15 through 22 is completed as to such policy or contract and is delivered with the policy, or is delivered to the applicant at the time application is made or by separate communication and acknowledgment of receipt or certification of delivery of such disclosure form is requested by the insurer. In the event that the policy or contract is issued on a basis other than that applied for, the outline of coverage must accompany the policy or contract when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name: 'NOTICE: Read this outline carefully. The coverage you originally applied for has not been issued. This policy is therefore not identical to the coverage you requested.' Except as otherwise provided the appropriate disclosure form for policies or contracts providing hospital coverage which only meets the standards of section 12 shall be that statement contained in section 20. The appropriate disclosure form for policies providing coverage which meets the standards of both section 7 and 8 shall be the statement in section 17. The appropriate disclosure form for policies providing coverage which meets the standards of both sections 7 and 10 or sections 8 and 10 or section 7, 8 and

10 shall be the statement contained in section 19. Appropriate changes in terminology may be made in the disclosure forms in the case of contracts of hospital or medical service corporations. Disclosure forms required by the laws or regulations of New York, Georgia or California shall be considered as not varying in any essential way from those mandated by this regulation and these forms, or any others that do not vary in any essential way may be used in lieu of those required by this regulation."

Violation: The policy is a Restricted Benefit Health Insurance Policy as defined by Section 13 of Regulation 2-74. The policy fails to utilize the disclosure form or an appropriate substitute as required by the regulation.

9. Regulation 2-74, Section 23:

"(1) Application forms shall contain a question to elicit information as to whether the insurance to be issued is presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

"(2) An agent or insurer soliciting the sale, upon determining that the sale would involve replacement, shall furnish to the applicant, at the time of taking the application, or before the policy is issued, the notice described in (3) below. A copy of such notice shall be left with or retained by the applicant and a signed copy shall be retained by the insurer.

"(3) The notice required by (2) above shall provide, in substantially the following form:

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT
AND SICKNESS INSURANCE

"According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by____________Insurance Company. For your own information and protection, certain facts should be pointed out to you which could affect your rights to coverage under the new policy.

"1. Health conditions which you may presently have, may not be covered under the new policy. This could result in a claim for benefits being denied which may have been payable under your present policy.

"2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

"3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

"4. It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also your duty to make sure you understand all the relevant factors involved in replacing your present coverage.

"The above 'Notice to Applicant' was delivered to me on (date).

"______________________"

Violation: The policy and application fail to utilize the disclosure form or an appropriate substitute.

10. Massachusetts General Laws Chapter 175, Section 22:

"No policy of insurance by a company under the authority of section twenty-four hundred and eight and one hundred and ten, and no contract or agreement entered into by the trustee of any trust fund authorized by chapter one hundred and fifty-one D, shall contain a provision excluding liability on the part of the insurance company or health and welfare fund for hospital, medical or surgical expenses if the insured is hospitalized or receives medical or surgical treatment in a soldiers' home established by the commonwealth. Any such provision shall be void. . . ."

Violation: The policy is in violation of this Section because it excludes liability for expenses incurred or charges made if the policy holder is treated in a soldiers' home established by the Commonwealth and because it excludes charges and expenses for services rendered by a state agency, including the state Veterans Administration and facilities contracted for by the United States which, in some cases, may include soldiers' homes operated by the Commonwealth.

11. Massachusetts General Laws Chapter 175, Section 47B:

> "Any blanket or general policy of insurance described in subdivision (A), (C), or (D) of section one hundred and eight which provides hospital expense and surgical expense insurance... shall, provide benefits for expense of residents of the commonwealth covered under any such policy or plan, arising from mental or nervous conditions. . ."

Violation: The policy does not provide benefits for the treatment of mental or nervous conditions to the extent required by the statute. The policy does make reference to coverage for such conditions, but fails to set forth the extent of coverage.

12. Massachusetts General Laws Chapter 175, Section 108, Paragraphs 2(a), (2A):

> "2. (a) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this commonwealth: until a copy of the policy and the table of rates or manual or risks of the company has been on file with the commissioner for at least thirty days, unless before the expiration of said thirty days the commissioner shall have approved the policy in writing; nor if the commissioner notifies the company in writing that in his opinion the form of said policy does not comply with the laws of the commonwealth, specifying the reasons for his opinion, provided that such action of the commissioner shall be subject to review by the supreme judicial court; nor unless: . . .
>
> "(2A) It provides that if the insurer denies liability and refuses to make payment on the basis of any provision contained in the policy relating to a pre-existing condition, illness or injury, the insurer shall transmit to the insured together with the notice of denial of liability documented evidence of specific instances of actual treatment or observation of such pre-existing condition, illness or injury in all cases except those of a confidential nature."

Violation: The policy fails to provide that if a claim is denied under a pre-existing condition exclusion, the company will send with the denial the non-confidential documentation of the actual treatment or observation of the pre-existing condition.

13. Massachusetts General Laws Chapter 175, Section 108, Paragraph 8A:

> "A. The commissioner may, within thirty days after the filing of a copy or form of such a policy, disapprove such form of policy if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy. If the commissioner shall notify the insurer which has filed any such form that it does not comply with the provisions of this section it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any policy. In such notice the commissioner shall specify the reasons for his disapproval and state that a hearing will be granted within twenty days after request in writing by the insurer."

Violation: The policy form and riders contain unreasonably low benefits in relation to the premium charged and contain provisions which, in letter and spirit, are unjust, unfair, inequitable, misleading and deceptive and encourage misrepresentation as to the policy. The provisions of these policies and riders are structured such that it is highly improbable or impossible for the policy holder to collect benefits to the extent promoted in the policy. The average loss ratio averages substantially below 30%.

UNION FIDELITY

LIFE INSURANCE COMPANY

A Stock Company

Trevose, Pennsylvania

MEDICARE SUPPLEMENT POLICY

In this Policy, you the Insured, will be referred as "you," "your," or "yours," and Union Fidelity Life Insurance Company of Trevose, Pennsylvania will be referred to as "we," "our," or "us."

We insure you, the Insured, against loss incurred by the Covered Persons named in the Policy Schedule or application as Insured(s) and will pay benefits for loss incurred hereunder resulting from injury or sickness, to the extent herein provided.

All periods of insurance herein shall begin and end at Twelve (12) O'clock Noon, Standard Time, at the place you reside.

CONSIDERATION

This Policy is issued in consideration of the payment of the first premium in advance of the Effective Date shown on the Policy Schedule and statements made in your application which is attached to, and made a part of this Policy. The Policy takes effect on the Effective Date provided the first premium is paid and may be continued in effect beyond the initial term subject to the provisions titled "Renewable At The Option of The Company Subject to Adjustable Premiums" and "Grace Period."

NOTICE OF INSURED'S RIGHT TO EXAMINE POLICY FOR 10 DAYS

If for any reason you are not satisfied with this Policy, you may surrender it by delivering it or mailing it, within ten days from the date you receive it, to our Home Office at Trevose, Pennsylvania or to the agent through whom it was purchased. Immediately upon such delivery or mailing, this Policy shall be deemed void from the beginning and any premium you have paid for it will be refunded to you.

RENEWABLE AT THE OPTION OF THE COMPANY SUBJECT TO ADJUSTABLE PREMIUMS

This policy cannot be cancelled or modified by the Company, except that the Company reserves the right to decline to renew this policy if:

(1) premium is not paid on or before the dates due or within the Grace Period; or
(2) all renewals are declined on all policies bearing this form number in the state of residence of the Insured:

No refusal of renewal will affect any existing claim under this policy.

The premium for this policy or any attached riders cannot be changed unless like changes are made on all policies of this Form issued to persons of the same classification residing in the Insured's then state of residence.

PRE-EXISTING CONDITIONS

A "pre-existing condition" is defined as a condition which became evident because there was a clear, distinct symptom or symptoms of the disease, illness, sickness, malady or condition demonstrable prior to the Effective Date of coverage for the Insured with the occurrence of such symptoms being evident within 12 months prior to the Effective Date of coverage for the Insured and in which, in the opinion of a legally qualified physician, would (1) indicate that the disease, illness, sickness, malady or condition probably began and manifested itself before the Effective Date of the coverage for the Insured, and (2) would cause an ordinarily prudent person to seek diagnosis, care or treatment.
A condition will cease to be considered "pre-existing" after the policy has been in force for six (6) months from the Effective Date.

HOSPITAL BENEFITS

When a Covered Person is confined in a Hospital as a Resident Patient as a result of injury or sickness we will pay:

a) The first [One hundred and forty-four dollars ($144.00)] of expense, which is not covered by Medicare:

b) The reasonable expense incurred for the first three pints of blood used during each Benefit Period up to $35.00 per pint.

c) [Thirty-six dollars ($36.00)] per day for each day of hospital confinement from the [sixty-first (61st)] day of confinement to the [ninetieth (90th)] day of confinement for each Benefit Period;

d) [Seventy-two dollars ($72.00)] per day for each day of hospital confinement from the [ninety-first (91st)] to the [one hundred and fiftieth (150th)] day of confinement of each Benefit Period while using the Lifetime Reserve as defined by Medicare Law 1-1966 TITLE XVIII and its amendments;

e) 80% of the reasonable and customary charges incurred during each Benefit Period for a semi-private room (or a private room if Medicare has been paying for such accommodation), and 80% of the reasonable and customary charges incurred during each Benefit Period for miscellaneous hospital services from the [one hundred and fifty-first (151st)] day of Hospital Confinement or from the [first (1st)] day of Hospital Confinement following the full utilization of the Lifetime Reserve days of coverage as defined by Medicare Law 1-1966 TITLE XVIII and its amendments; up to a maximum of $10,000.

SURGICAL AND PHYSICIANS' VISITS BENEFITS

When a covered Person incurs expenses as a result of injury or sickness, in excess of the initial Medicare Part B deductible, we will pay:

(a) 20% of the reasonable expense you incur for the in-hospital services of an operating physician or surgeon when any surgical operation or procedure is performed;

(b) 20% of the reasonable expense you incur for Hospital room visits of a licensed physician, not to exceed one visit per day;

(c) 20% of the first $ 1,000 of out-of-hospital charges for the reasonable and customary expense incurred for: specialists services (anesthesiologists, radiologists, pathologists), x-ray and radium therapy (materials and technicians), diagnostic tests and x-rays (doctor's office or clinic), drugs and biologicals (not self-administerd), dressings, casts and splints (doctor's office or clinic), and out-patient hospital care (other than diagnostic tests).

No payments shall be made by us toward that part of incurred expenses for which a Covered Person is entitled to have payment made under Medicare of under any other Federal or State legislation (whereby there is no legal obligation to pay for such expense) such as Workman's Compensation or Occupational Disease Laws or services rendered by any agency of a state government or of the Federal government, including Veteran's Administration. If a Covered Person is not eligible or does not qualify to receive payments for hospital confinement under any Federal Medicare Legislation or plan, benefits will be paid as though he were so eligible and so qualified and received such payments.

If the hospital is not a participating hospital or is not eligible or does not qualify to receive payments from the United States Government or its Agencies on account of regular hospital confinement of persons entitled to have such payments made on their behalf under any Federal Medicare Legislation or plan, benefits will be paid as though the hospital were participating and were so eligible or so qualified and received such payments.
If, from time to time, changes are made in such legislation or deductibles and/or co-insurance amounts which affect the risk assumed by us, an appropriate adjustment in benefits or in both premium and benefits may be made.

SKILLED NURSING FACILITY BENEFITS AFTER YOU LEAVE THE HOSPITAL

If your physician determines that you need daily skilled nursing care or skilled rehabilitation service at a skilled nursing facility for further treatment of a condition for which you were treated in the hospital, having been hospitalized for at least 3 consecutive days, we will pay:

(a) [$18.00] a day for such treatment, beginning with the 21st day of confinement to the 100th day of confinement.

(b) [$20.00] a day for such treatment, for the 101st to the 365th day of confinement.

The above benefits will be paid if you are admitted to a skilled nursing facility within 14 days after leaving the hospital.
If you are discharged from a skilled nursing facility and are re-admitted within 14 days, your coverage will continue without a new 3-day stay in a hospital.

AMBULANCE EXPENSE BENEFIT

If, as a result of injury or sickness, it is necessary to transport a Covered Person by ambulance to a hospital where such Covered Person becomes confined as a Resident Patient within 24 hours of such trip, we will pay you 20% of the reasonable expense incurred by the covered Person for such transportation, up to One Hundred Dollars ($100.00) per year, not exceeding two trips per year.

NURSE-AT-HOME BENEFIT

If, as a result of injury or sickness, a covered person shall require, upon the recommendation of a legally qualified physician or surgeon, the care and attention of one or more Registered Nurses (R.N.) while such Covered Person is continuously confined at home immediately following a period of hospital confinement of three (3) consecutive days or more, we will pay you the actual expense incurred for each nursing shift of eight or more hours per day, not to exceed two shifts per day or Twenty dollars ($20.00) for each shift. We shall pay for the period that such service is required, but not to exceed thirty (30) days for any one injury or sickness.

PRESCRIPTION DRUGS BENEFIT

When as a result of injury or sickness, a Covered Person is confined within a Hospital as a Resident Patient for at least 3 consecutive days and benefits are payable under this Policy for such confinement, we will pay for the regular and customary charges of Prescription Drugs used within 30 days following discharge from the Hospital, not to exceed $50.00 for any one 30 day period, and limited to 2 such 30-day periods per year.
To be eligible for payment such prescription drugs must be prescribed by a physician or surgeon and be used for treatment of the injury or sickness which caused the preceding period of the hospital confinement.
Prescription drugs used during hospital confinement are not covered under this provision.

DEFINITIONS

"Medicare" means The Health Insurance for the Aged Act, TITLE XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

"Covered Person(s)" means you or your spouse, both of whom must be 65 or older. Only those Covered Persons listed in the Policy Schedule or application as Insured are covered under the Policy.

"Sickness" means sickness or disease which is first manifested after the Effective Date of the Policy and while the Policy is in force.

"Injury" means accidental bodily injury which is sustained after the Effective Date of the Policy and while the Policy is in force.

"Hospital" means hospital as defined by Medicare Law 1-1966 TITLE XVIII, or a legally operated institution which maintains and regularly uses on its premises or in facilities available to the hospital a laboratory, X-ray equipment and operating room where major surgical operations may be performed; maintains permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed physician; provides 24-hour-a-day nursing service by graduate Registered Nurses; and maintains on the premises the patient's written history and medical records. The word "hospital" shall not include any facility for whose service payment would not be legally required in the absence of insurance nor any facility contracted for or operated by the United States Government for the treatment of members or ex-members of the armed forces; and shall not include any institution or part thereof used, other than incidentally, as a place for rehabilitation, rest, the aged, drug addicts or alcoholics, a mental institution (except as provided herein for up to sixty days per calendar year), sanitarium, nursing or convalescent home, a long term nursing unit or geriatrics ward, or as a skilled nursing facility for the care of convalescent, rehabilitative or ambulatory patients.

"Resident Patient" means a person confined overnight in a Hospital for necessary treatment of injury or sickness. This shall not include a person receiving any form of rest, nursing, convalescent, rehabilitative, or custodial care.

"Semi Private Room" means a hospital room with not less than two beds.

"Reasonable Expense" means the usual and customary fee or charge, to persons of the same age whose financial means are substantially similar to yours, independent of this insurance, for the services rendered or supplies furnished in the area where such services are rendered or supplies furnished, provided such supplies are recommended and approved by a licensed physician or surgeon, other than yourself.

"Benefit Period" means a period commencing after the Policy Effective Date which begins with the First day a Covered Person is confined in a hospital as a Resident Patient as a result of injury or sickness and ends at the close of 60 consecutive days on each of which he is not confined in a hospital or skilled nursing facility.

"Effective Date" of this Policy is the date shown on the attached Policy Schedule.

"Skilled Nursing Facility" means skilled nursing facility as defined by Medicare Law 1-1966 TITLE XVIII which is a specially qualified facility which is staffed and equipped to furnish skilled nursing care, skilled rehabilitation services and other important related health services.

"Physician or Surgeon" means a legally qualified physician or surgeon other than the Covered Person whose loss is the basis of claim, who is recognized by the law of the state in which treatment is received as qualified to treat the type of injury or sickness causing loss for which claim is made.

"Nurse" means a graduate Registered Nurse (R.N.) who is not immediately related to you.

"Continuously Confined At Home" means necessary and continuous confinement at home, under the care of a physician. Such confinement shall not be terminated by reason of necessary visits to the doctor's office or hospital nor for resting out-of-doors on the porch or in the yard or premises on the advise of a physician.

CONTINUATION OF OWNERSHIP

If you should die, while this Policy is in force for you and your spouse, then your spouse shall assume all the incidents of ownership of this Policy.

RIGHT TO CONTINUE COVERAGE

If your marriage is terminated, while the Policy is in force for you and your spouse, the spouse has the right to purchase coverage for the same type of policy with an effective date the same as the policy under which you and your spouse are insured.

EXCLUSIONS

We will not pay you benefits for any loss caused by or resulting from: (1) war or any act of war; (2) any mental disorder (except as provided herein for up to sixty days per calendar year); (3) intentionally self-inflicted injury; or (4) hospital confinement in any institution for whose services payment would not be legally required in the absence of insurance, or any facility contracted or operated by the United States Government for the treatment of members or ex-members of the armed forces.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy, including the application, endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. None of our agents has the authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: (a) After two (2) years from the date of issue of this Policy no misstatements except fraudulent misstatements made by the applicant in the application for such policy shall be used to void the Policy or to deny a claim for loss incurred or disability (as defined in and if covered by this Policy) commencing after the expiration of such two-year period. (b) No claim for loss incurred or disability (as defined in this Policy) commencing after 6 months from the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of coverage of this Policy.

GRACE PERIOD: Unless not less than thirty days prior to the premium due date we have delivered to you or have mailed to your last address as shown by our records, written notice of our intention not to renew this Policy, in accordance with the Renewal Agreement, beyond the period for which premium has been accepted a Grace Period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which Grace Period the Policy shall continue in force.

REINSTATEMENT: If any renewal premium be not paid within the time granted you for payment, a subsequent acceptance of premium by us or by any agent duly authorized by us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by us, or lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval of such application. The reinstated Policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects you and we shall have the same rights thereunder as existed under the Policy immediately before the Due Date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given us within thirty (30) days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of you to us at our Home Office, Trevose, Pennsylvania, or to any of our authorized agents, with information sufficient to identify you, shall be deemed notice to us.

CLAIM FORMS: Upon receipt of a notice of claim, we will furnish to you such forms as are usually furnished by us for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice you shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOFS OF LOSS: Written proofs of loss must be furnished to us at our said Office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which we are liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this Policy for any loss, other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payments will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

PHYSICAL EXAMINATIONS: We shall have the right and opportunity to examine you or your covered spouse at our own expense when and as often as we may reasonably require during the pendency of a claim hereunder.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years (5 years — Kansas; 6 years — South Carolina) after the time written proof of loss is required to be furnished.

MISSTATEMENT OF AGE: If your age has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

OTHER INSURANCE IN THIS COMPANY: Insurance effective at any one time on you under a like policy is limited to the one such policy elected by you and we will return all premiums paid for all other such policies.

UNPAID PREMIUM: Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

CONFORMITY WITH STATE STATUS: Any provision of this Policy, which, on its Effective Date, is in conflict with the statutes of the state in which you reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

INTOXICANTS AND NARCOTICS: We shall not be liable for any loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

In Witness Whereof, we have caused this Policy to be signed by our President and secretary.

Secretary

President

POLICY SCHEDULE

ALWAYS GIVE YOUR POLICY IDENTIFICATION NUMBER WHEN CONTACTING THE COMPANY

IDENTIFICATION NO.	OFFICE	EFFECTIVE DATE OF POLICY
123456	Home	5-11-77

NAME AND ADDRESS OF INSURED

John A Doe
123 Main St.
Trevose PA 19047

FORM NO.	MONTHLY RENEWAL PREMIUM	INITIAL PREMIUM INCLUDING POLICY FEES	YOUR NEXT PREMIUM PAYMENT IS DUE ON
DR1-8120-MA	$1X.X	$XX.XX	6-1-77

In Witness Whereof, we have caused this Policy to be signed by our President and secretary.

Secretary

President

POLICY SCHEDULE

ALWAYS GIVE YOUR POLICY IDENTIFICATION NUMBER WHEN CONTACTING THE COMPANY

IDENTIFICATION NO.	OFFICE	EFFECTIVE DATE OF POLICY
123456	Home	5-11-77

NAME AND ADDRESS OF INSURED

John A Doe
123 Main St.
[illegible] PA 19047

FORM NO.	MONTHLY RENEWAL PREMIUM	INITIAL PREMIUM INCLUDING POLICY FEES	YOUR NEXT PREMIUM PAYMENT IS DUE ON
DRI-8120-MA	$1X.X	$1XX.XX	6-1-77

The Commonwealth of Massachusetts
Department of Banking and Insurance
Division of Insurance
Leverett Saltonstall Building, Government Center
100 Cambridge Street, Boston 02202

Telephone No.
727-3386

TELEPHONE
727-3397
AREA CODE 617

June 8, 1978

Patricia A. Pithie, Policy Analyst
Union Fideltiy Life Insurance Co.
Union Fideltiy Office Park
Trevose, Pennsylvania 19047

Re: DRI-8120-MA
DRI-61645(378) WP

Dear Sir:

The Policy Approval Section of the Insurance Department received your correspondence on May 31, 1978, which contained the following form(s) : Same as above.

An examination of said form(s) shows that it appears to conform to the pertinent requirements of Chapter 175 of the General Laws of Massachusetts, and it (they) is (are) hereby approved.

Very truly yours,

Budreckis

Algirdas Budreckis, Head
Policy Approval Section

AB/ds

PAS-7

December 14, 1978

The Honorable James M. Stone
Commissioner of Insurance
Commonwealth of Massachusetts
100 Cambridge Street
Boston, Massachusetts 02202

Dear Commissioner Stone:

Enclosed please find two tentative copies of the market conduct review of the Union Fidelity Life Insurance Company.

If you have any questions relative to this report, please do not hesitate to contact either Mr. Arthur Hills or myself.

Very truly yours,

James T. McBride

JTM:djwe

Encs:

((#57CR

December 7, 1978

NAIC Market Conduct Examination
Subcommittee
The Honorable Richard L. Block
Director of Insurance
State Office Building
Juneau, Alaska 99881

The Honorable James M. Stone
Commissioner of Insurance
100 Cambridge Street
Boston, Massachusetts 02202

The Honorable William J. Sheppard
Commissioner of Insurance
108 Finance Building
Harrisburg, Pennsylvania 17120

Dear Commissioners:

At the request of the Commonwealth of Massachusetts Division of of Insurance, we have performed a market conduct review of the Union Fidelity Life Insurance Company of Trevose, Pennsylvania. Union Fidelity Life Insurance Company is a life, accident and health insurance company which solicits insurance via sales agents, direct mail and newspaper advertisement. It sells disability, accident only, hospital indemnity, Medicare supplement and basic life insurance. The Company's admitted assets and premium income at, and for, December 31, 1977 were $47,569,509 and $43,657,520 respectively. Premium income in Massachusetts for the year ended December 31, 1977 amounted to $1,663,227.

Union Fidelity Life Insurance Company, which was founded in 1958, is a wholly-owned subsidiary of Union Fidelity Investment Corp. which in turn is a wholly-owned subsidiary of Union Fidelity Corporation. In September 1977, Filmways, Inc., a California based diversified entertainment/publishing concern, purchased 62% of Union Fidelity Corporation from its Chairman. In February 1978, Filmways, Inc., acquired the remaining 38% equity in Union Fidelity Corporation.

The procedures that were performed in the market conduct review, under the direct supervision of the Commonwealth of Massachusetts Division of Insurance, are outlined in the September 14, 1978 "Special Market Conduct Program" which was prepared jointly by the Division of Insurance of the Commonwealth of Massachusetts and appointed outside attorneys and accountants. Though some modification of procedures occured during the execution of the market conduct review, the aforementioned program represents an accurate description of the scope of the work performed. The examination commenced on August 7, 1978, on-site procedures began on August 29, 1978, and field work was substantially completed by October 13, 1978.

The reports that follow describe the findings of Touche Ross & Co., who were appointed to perform market conduct review procedures that were audit/accounting related, Arthur J. McCabe, II, Esquire, who was appointed to perform market conduct review procedures requiring legal expertise, and R & L Associates, Inc., who were appointed to conduct market research activities.

Very truly yours

Alan J. Wright
Acting Chief Examiner

Touche Ross & Co.

Arthur J. McCabe, II
Esquire

Michael Rapperport
R & L Associates

General Comment:

The violations pointed out in this report must be corrected and the recommendations implemented. The Company will submit to the Division of Insurance within sixty days of publication date of this examination report, a report stating how these violations have been corrected and recommendations implemented. New cancer expense policy and application forms and related promotional material must also be submitted within sixty days. The Legal Bureau of the Division of Insurance will consider the institution of disciplinary proceedings where appropriate.

Alan J. Wright
Acting Chief Examiner

December 8, 1978

The Honorable James M. Stone
Commissioner of Insurance
Commonwealth of Massachusetts
100 Cambridge Street
Boston, Massachusetts 02202

Dear Commissioner:

At your request we have participated in the market conduct review of the Union Fidelity Life Insurance Company of Trevose, Pennsylvania, as summarized in the December 7, 1978 letter to yourself and Commissioners Block and Sheppard.

The results of our part of the market conduct review procedures are contained in the following thirteen pages, which we would be happy to discuss with you or your representatives at your convenience.

Very truly yours,

Touche Ross & Co.

I. ADVERTISING AND PROMOTIONAL MATERIAL

We reviewed selected promotional material to determine the authenticity and fairness of factual representations contained therein and noted the following:

1. The Rural American Group Insurance Trust letter used in the Company's solicitations makes the following representation, "The accidental death rate for farm residents is 26.4% higher than the national average". The relevant 1976 National Safety Council statistics are as follows:

National average	46.6 deaths per 100,000 people
Farm residents	54.0 deaths per 100,000 people

From this we compute the farm resident rate to be 15.9% higher than the National Average and not 26.4% higher, as is stated.

The Company indicated that the 26.4% statistic was based upon the results of an early study. However, the 1976 National Safety Council statistics were available when the Rural American Group Insurance Trust letter was distributed.

2. The Direct Consumer Trust mailing, which is used by the Company to solicit accidental death and dismemberment insurance, states "In one year over 10,300,000 Americans were disabled by accidents..." The National Safety Council states that 370,000 (or 3.6%) of the 10,300,000 Americans were permanently disabled. Permanent disability, as defined, ranges from the permanent stiffening of a joint or a finger amputation, to permanent, complete crippling.

Since only accidents involving the dismemberment of an extremity would be covered by the policy being solicited, not all the 370,000 permanent impairments would be eligible for benefits under the policy terms. The Massachusetts Division of Insurance should evaluate whether the Company's use of the statistical representation noted is relevant to the coverage being offered by the Company.

3. The Rural American Group Insurance Trust letter makes the following representation, "There were over 500,000 disabling accidents on farms last year alone". According to the 1976 National Safety Council statistics:

- There were 510,000 disabling injuries to farm residents. These include motor vehicle accidents and other injuries occuring on and off the farm.
- There were 190,000 work-related disabling injuries occuring on the farm, and 150,000 of these happened to farm workers.

- In 2% of farm injuries there was a "permanent injury". (A permanent injury is defined as loss of full use of any part of body, amputation, etc.)

According to National Safety Council statistics, in 2% of disabling farm accidents a potential insured would be eligible for benefits under the terms of the policy being offered in the direct mail solicitation. The Massachusetts Division of Insurance should evaluate whether the Company's use of the statistical representation noted is relevant to the coverage being offered by the Company.

4. The following was found regarding Testimonial Letters:

- A testimonial letter was reprinted from an individual from the State of California. The first part of the letter was printed. The last paragraph of the letter, which comments negatively upon claim settlement procedures, was not printed.

- Two of the sixteen testimonial letters examined originated from insureds who had never submitted a claim to Union Fidelity. In one of these cases the testimonial letter was written prior to the issuance of a policy by the Company.

5. We performed an analysis of the premium rates offered in "low group rate" solicitations and determined that the rate being offered was 5% lower then was being offered to individuals, as follows:

	Monthly Rate Offered to		Monthly Difference
	American School Food Service Association	Individuals	
$150,000 Cancer coverage		$4.40	
$ 50,000 extra rider		1.45	
$200,000 Cancer coverage	$5.54	$5.85	$.31

6. We performed an analysis of benefits offered under the $200,000 cancer plan and determined that the events that would have to occur in order to collect the maximum benefits, are as follows:

- The following medical expenses would have to be incurred:

Maximum benefit		$200,000
Physician	$1,200	
Nursing	1,200	
Drugs/medicine	500	
Surgery	1,000	
Anesthesia	140	
Blood and plasma	600	
X-Ray therapy	2,000	
Ambulance	1,000	
Medical Benefits	$7,640	(7,640)
Available		192,360

Carried forward	$192,360
.. The policy pays room and board benefits, as follows:	
Day 1 through day 7 at $120 per day	(840)
Day 8 through day 90 at $80	(6,640)
Available after 90 days	184,880
.. After 90 days, the policy pays room and board at actual cost. Using $158 per day (the Company's estimate used in advertising material), an additional 1,005* days would be covered:	
Day 91 through day 1,095 (3 yrs.) @ $158	(158,790)
Remaining	$ 26,090

* Coverage does not extend beyond 3 years of diagnosis.

Since coverage does not extend beyond three years, an insured could collect $173,910 using the Company's advertised average room and board rate of $158 per day.

Other major policy exclusions are listed below:

- The policy does not cover losses due to or associated with:
  - Cancer diagnosed by a Pathologist before the effective date of the policy.
  - Confinement in any institution where the insured is not required to pay in the absense of insurance.
  - Rest homes, extended care facilities or nursing home care that does not follow cancer hospitalization.
  - Cancer first manifested during the first 120 days the insurance is in force is not covered for two years.

II. COMPLAINTS

1. We reviewed the Company's procedures for recording, processing and controlling complaints and noted the following:

   - Union Fidelity maintains decentralized systems for handling complaints. Each department has its own procedure and generates its own reports. When correspondence is received in a department, it is usually responded to in that department and not referred to another department.

   - Partly due to the above, no uniform procedures exist for the following:

     - .. Logging complaints
     - .. Distinguishing between complaints and inquiries
     - .. Coding and classifying complaints and inquiries for summarization purposes
     - .. Summarizing compiled data
     - .. Distributing summaries for review.

2. We judgementally sampled the complaint logs. The results are presented below:

	Department			
	Policy Service	Claims	Agency	Insurance
Number of written complaints or inquiries logged during examination period	32	1,625	Combined 2,540	
Number selected for review	32	31	40	26
Average response time (in days)	22	16	20	17
Median response time (in days)	15	15	15	16
Range in days	5 - 46	2 - 31	1 - 39	1 - 36

3. A brief description of the procedures in each department follows:

   - Policy Service Department - A list of complaints and inquiries received by telephone is kept and summarized weekly. No complete record of written inquiries, by type, date of receipt or ultimate disposition is maintained.

   - Claims Department - A log for written complaints is maintained and sumarized monthly. A log of complaints received by telephone is maintained by type and summarized monthly.

- Agency Department - The Agency Department maintains a complaint and inquiry log that is summarized weekly, and shows the date received and the disposition of the complaint. An Agency log is also maintained from memos received from the Policy Service Department. The Agency Department maintains a file of all inquiries chronologically.
- Insurance Department - The Insurance Department maintains a log by date of inquiry or complaint, the reason for the complaint and the disposition. It is kept chronologically by State and is summarized weekly by State and by type of complaint.

Based upon our observations in these areas, the Massachusetts Division of Insurance should consider recommending that the Company implement standardized procedures to insure that all written complaints/inquiries and significant telephone complaints/inquiries are properly recorded, summarized into meaningful categories, and disposed of in a timely manner. A periodic independent review of these activities by responsible Company management might also be an appropriate recommendation from the Division of Insurance.

4. We entered the mail facility three times in the first two weeks on a no-notice basis. We were observant for and personally copied the following items:

- Consumer complaints and inquiries.
- State Insurance Department correspondence.
- Any correspondence indicative of marketing problems.

Seventy-nine (79) pieces of correspondence were selected, logged and followed up on two weeks after receipt to determine if the Company was responding in a timely, responsible manner. The disposition of the 79 pieces of correspondence was as follows:

• Answered	27
• Unanswered	42
• Crossed in mail	10
	79

These results are not inconsistent with the results of the analysis of the Company's complaint logs,as discussed above.

5. We obtained and read complaints, disciplinary actions and other information received from States, other than the Commonwealth of Massachusetts, relative to promotional material. All 23 States from whom we examined correspondence had complained to the Company regarding some aspect of its advertising and had requested that Union Fidelity change certain related items.

III. AGENTS

1. Union Fidelity contracts with General Agents to market its policies. General Agents, in turn, contract with sub-agents, making an independent financial arrangement. Sub-agents do not contract with Union Fidelity, but they must sign an Agents Information Questionnaire and a Request for Agent's License and Acknowledgement of Conditions.

   Payment of all commissions are made directly to General Agents who in turn compensate sub-agents. Commission rates vary among General Agents depending upon the agent, the type of policy, and the policy year, but generally fall within these ranges:

   - A & H 40-100% first year/10-20% renewals
   - Life 20- 80% first year/0-17½% renewals.

2. We reviewed records to determine if the list of agents provided to us by Union Fidelity from Marketing Department files is all inclusive. We noted that no personnel records are maintained on Company agents since general agents are considered self-employed and sub-agents are employed by General Agents. Therefore, the completeness of the agent list provided to us by the Company cannot be verified from another source.

3. We requested from the Company information regarding initial and continuing agent education and were informed that Union Fidelity does not conduct training courses for agents, nor does it prepare any educational materials specifically for the purpose of training agents.

4. We reviewed information on agent applications and rejections during the examination period. Of 32 applications received, 3 were rejected by the Company.

5. A total of 50 agents were licensed to sell Union Fidelity products in the Commonwealth of Massachusetts during the examination period (1/1/77 to 8/31/78). A summary of their background is as follows:

No. of Agents	Background
4	- No previous work history
1	- No previous insurance experience
7	- Up to 1 year insurance experience
13	- 1 - 5 years insurance experience
13	- 5 - 10 years insurance experience
10	- 10 - 20 years insurance experience
2	- Over 20 years insurance experience
50	

6. There were twenty-nine (29) agents terminated during the examination period. Seventeen (17) of the twenty-nine(29) were terminations resulting from Massachusetts Division of Insurance investigations. The annualized agent turnover during the examination period was approximately 83%.

Other explanations given for the termination of agents are:

Lack of production	8
Writing bad check	1
Signing applications not seen by policyholder	1
Other	2
	12

7. The Company indicated it is not currently engaged in a lead program with agents in the Commonwealth of Massachusetts and has not been during the examination period. The Company prints response cards for its agents, but does not mail them or provide the mailing list.

8. The Company does buy mailing lists for its mass marketing effort from a mail list broker. Examples of these are:

Category	Source
Senior Citizens	Senior Citizens Unlimited
Rural Americans	List is compiled by zip code
Members of the Catholic religion	Subscribers to the Catholic Digest
Members of the Jewish religion	Subscribers to Jewish publications.

The Massachusetts Division of Insurance should evaluate whether these agent-related findings warrant recommendations to the Company regarding agent selection, training and supervision.

IV. UNDERWRITING

1. We reviewed Company procedures in the underwriting and rating areas. A brief description follows:

- **Mass Marketed Policies:**

  Applications received by mail are sent to the Mass Marketing Issue Department. The applications are recorded and stamped received. If money is received the amount is also recorded. Then, the applications are sorted into medical applications (i.e., cancer, medicare supplements) and non-medical applications (i.e., hospital and indemnity). They are further separated into the different target policies and further into categories by applicant answers to application questions. Applications are then batched into groups of 50, summarized sequentially and logged. They are microfilmed in sequential number and keypunched into the EDP system. At this point, for complete applications, the computer generates a policy, personalized letter, and a premium notice. Applications that require additional information are held in a pending file until all information is obtained. Applications are rejected if, for instance, on a cancer policy the applicant writes that he has cancer. Medicare applications are rejected if the applicant has been in a nursing home or has been hospitalized during the past 60 days. At no time are medical applications sent to an underwriter or rater. Only some of the life insurance applications are processed through underwriting.

- **Agency Marketed Policies:**

  Agency Service Department receives applications from the agent They are then distributed to new business clerks to check the following:

  .. Agent is licensed with the Company. This is checked against a company computer listing of licensed agents.

  .. That the form is approved in the State in which the agent has sold it. This is checked against an approved list.

  .. That the rates on the application are accurate. This is checked by reference to the brochure to which it pertains.

  .. That the money received is correct. This is checked by reference to the agent's contract.

  The applicant is checked to see that he is not applying for coverage which he already has with Union Fidelity. The applicant's listed diseases or illnesses are reviewed and some are further investigated by contacting a physician. After evaluating all data, the applications are, if accepted, typed and sent to the Policy Issue Department and a policy is issued

- if rejected, a letter is sent to the applicant explaining the reason for the application rejection.

2. We reviewed selected applications for the following attributes:

- Determine whether the application was subjected to rating procedures and that the premium was properly calculated.
- Determine whether coverage (as shown in Company information files) began at application date, acceptance date or other date in accordance with policy provisions.
- Determine whether any excessive payment was received from insured and that fees, if any, are disclosed and allowed by law.
- Determine whether questions and other correspondence from prospective policyholders included with the application were promptly handled prior to policy issuance.
- Determine whether applications which required medical examinations or medical statements by prospective policyholders were subjected to appropriate underwriting review by employees with sufficient expertise to make informed decisions at time of policy applications.
- Determine whether the application forms contained anything unusual relative to signature, completion of form, dates, etc.

Based upon a reliability level of 95%, expected error rate of 2%, upper precision limit of 5%, and a population of 8,060 applications received through Mass Marketing, we determined the sample size to be 123.

Based upon our sample results, we are 95% confident that:

- No more than 2% of these applications are subjected to rating procedures.
- No less than 98% of related premiums are computed correctly.
- No less than 98% of the related policies commence coverage in accordance with policy provisions.
- No less than 98% of related applicant correcpondence is handled prior to policy issuance.
- No more than 2% of related applications are subjected to underwriting review which require medical evaluations.
- No more than 2% of the related applications contain anything unusual relative to signature, clerical completeness or date.

3. We reviewed applications that were rejected and withdrawn by the Company during the examination period.

	Applications	Rejections	Rate
Mass Marketing	8,060	123	1.5%
Agency	1,319	37	2.8%

Of the 160 rejected applications, 24 were applications for cancer policies and 31 were applications for Medicare supplement coverage. We reviewed 37 of the rejected applications, all were rejected for medical reasons.

4. We reviewed 18 withdrawals and determined that most (13) were not issued because of over-insurance considerations.

5. We obtained from the Commissioner's files fascimile signatures of Massachusetts agents. On a test basis we compared agents' signatureswith those on applications. No exceptions were noted except that many applications tested contained the signature of sub-agents whose fascimile signatures we did not have.

V. CLAIM SETTLEMENT PROCEDURES

1. We obtained the following understanding of the Company's claim recording and payment procedures as follows:

   Claims are received through the mail and forwarded to the Data Base Integrity Department which opens the mail, edits it or separates it by type. Then the claims are sent to an initial adjuster. Claims are first input into the computer system prior to any settlement. The initial adjuster or the claims adjuster decides if the claim is to be paid, denied or put into a "pending" file. Adjusters whom the Company considers to be experienced and competent handle claims by themselves and, usually determine whether a claim is to be paid, denied, or pended. All work of trainees is checked to determine if a right decision has been made with regard to the settlement of the claim. As soon as a claim is received a file is set up for that policy number and any new correspondence or claims are filed with the original file.

2. We examined selected Massachusetts insureds whose claims on targeted policies have been rejected, determined the reason for the rejection, and communicated with selected rejected claimants. The results of our test follow:

   - Reasons for denial of claim:

.. Claim not covered by policy terms	54
.. Policy had lapsed	8
.. Relevant conditions not noted on application or health misstatements	7
.. Pre-existing policy	4
.. Other miscellaneous reasons	33
	106

   - Denied claimants contacted:

.. People who said they didn't understand their policy terms:	
- Have not cancelled policy since claim was denied	11
- Cancelled policy since claim was denied	1
.. People who were completely satisfied with the manner in which their claim was handled	1

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.. Deceased	1
.. People who couldn't remember making a claim or having a claim denied	4
	18

3. The claims submitted and denied during the examination period were as follows:

.. Claims submitted	5,335
.. Claims denied	1,119
Denial rate	21%

4. As of September 30, 1978, 4,216 claims were paid of the 5,335 that were submitted by Massachusetts residents during the examination period.

5. Of the 72 paid claims selected for examination:

- The average payment was $330 per claim.
- The average time from report date to paid date was 25 days.
- The range from report date to paid date was 2 to 269 days.
- The median time from report date to paid date was 9 days.
- The average premiums collected per policy was approximately $197.45.
- 7% of these claimants have subsequently cancelled their policy.
- 15% of these claimants have subsequently died.

6. We analyzed Company expense accounts for outside legal and medical services to determine if there are claims not properly recorded in the Company records. We found none.

VI. LOSS RATIOS

The Company has supplied us with the following loss ratio information related to Massachusetts insureds:

Line of Business	Earned Premiums	(A) Incurred Losses	Loss Ratio
2140 - Cancer benefit	151,700	37,400	24.6%
4430 - Intensive care	48,000	1,700	3.5%
4530 - Cancer skilled	2,500	1,000	40.0%
7250 - Agency cancer	9,900	3,700	37.5%
4510 - Mass Marketing cancer	4,700	1,600	34.2%
7760 - Agency Medicare Supplement	40,200	4,700	11.7%
4220 - Mass Marketing cancer	15,600	6,500	41.4%
2310 - Mass Marketing Medicare Supplement	66,400	12,300	18.5%
4450 - Mass Marketing Medicare Supplement	48,100	6,600	13.7%
4540 - Mass Marketing cancer	20,000	700	3.4%
7270 - Agency cancer	12,700	-0-	-0-
7790 - Agency Skilled Nursing Facility and Medicare Supplement	13,100	200	1.5%
TOTAL	432,900	76,400	17.6%

(A) Cumulative figures since issuance of plan.

Associates

POLICYHOLDERS OF

UNION FIDELITY INSURANCE COMPANY

* * *

A Study Conducted for

THE MASSACHUSETTS DIVISION OF INSURANCE

* * *

INTRODUCTION

The Massachusetts Division of Insurance, as part of its audit of Union Fidelity Insurance Company, decided to incorporate actual testimony from policyholders. The Division at this time is particularly concerned with the sales practices of companies who sell the so-called "dread" disease or cancer coverage policies. The Division believed that the testimony of actual policyholders would provide greater depth to its understanding of the actual knowledge, behavior, and understanding of consumers and the role that the insurance companies themselves play in the education of consumers.

The material covered in the questionnaire and the sample design were structured to mesh as closely as possible with the known sales practices of Union Fidelity Insurance Company. This report presents findings only from the actual surveys conducted among policyholders.

UNION FIDELITY INSURANCE COMPANY

Background

Union Fidelity sells primarily through the mail. Potential customers receive brochures which describe the policy and contain an application form. The company sells a variety of policies for both the so-called dread diseases (cancer and heart disease) as well as supplementary insurance for other types of health problems.

Questionnaire

The questionnaire (see Appendix I) was designed to obtain information in the following areas:

1 Other insurance coverage of the respondent; in particular Blue Cross/Blue Shield and Medicare. This knowledge was important primarily because of coordination of benefits clauses in the Blues.

2 Any experience with cancer policies by the respondent. This was to identify types of respondent.

3 Respondent purchasing mechanism (through an agent, through the mail, etc.) If the policy was purchased through an agent, that respondent's present and past experience with that agent.

4 If the policy was bought through the mail, respondent familiarity with the terms outlined in the brochure.

5 Reasons for buying cancer policies in general and this policy in particular. This area included:

   o Knowledge of the actual coverage provided by the policy
   o Ownership of other Union Fidelity policies
   o Experiences in buying any other Union Fidelity policies
   o Claim experience against Union Fidelity
   o Demographics and other background information about the respondent.

Sample Design

The sample was drawn by Union Fidelity personnel from its own policy records. We then drew a subsample of policyholders as follows:

- All individuals who had bought either a cancer policy or a Medicare supplement policy from Union Fidelity from the period July 1, 1978 to the present.
- All individuals who had bought either policy from January 1, 1978 to February 15, 1978.

Because of the unusually high numbers of refusals by policyholders and the high number of unlisted telephone numbers, this original sample was supplemented with individuals who had bought cancer policies in the period February 15, 1978, to April 1, 1978. The reasons for this unusually high number of refusals and unlisted numbers will be discussed below.

Interviewing

Interviewing was carried out by professional interviewers within Massachusetts during the latter part of October 1978. Interviews were conducted by telephone, and all interviewers had had previous experience with this type of interviewing, and they were also briefed on this particular questionnaire and sample.

Blue Shield. Only about 5% of the entire sample had neither Medicare nor Blue Cross/Blue Shield coverage.

Policy ownership

Still another characteristic related to the elderly was the large number of respondents who did not know that they had any cancer policy or indeed any policy with Union Fidelity. Again, this lack of recall of policy ownership was much less true among policyholders of the other two companies studied in this project.

About two thirds of the total sample knew they had a policy. Only about three fifths of those who Union Fidelity says have a cancer policy recall having the policy. This drops to only half of those 80 years of age or older.

Agents and brochures

The data substantiates that Union Fidelity policies are overwhelmingly purchased through the mail. As a result, we have no statistically significant data on agent behavior in the selling situation.

Over 80% of those who know they have a cancer policy recall having seen or read a brochure. A majority of the entire sample says that they have read the entire brochure. Respondents gave a wide variety of answers to questions about what they specifically remembered from reading the brochure. The two most common answers, which between them were given by about half of all respondents, touched on the costs and incidence of cancer.

Factors motivating choice of policy

The primary motivations cited by respondents for choosing the Union Fidelity was that it was the only cancer policy they had ever heard of or that it was made conveniently available through the mail. The underlying motivations for buying a cancer policy at all were related to fear of the disease itself or to its cost and widespread incidence among the population.

SUMMARY OF FINDINGS

Demographics

The single most significant characteristic of policyowners is their old age. In keeping with their age, they exhibit a number of other associated demographics, such as low income and a high number of widows.

	Total	Men	Women
Age			
Up to 59 years	10%	13%	8%
60-69 years	24	24	26
70-79 years	45	43	51
80 years and over	14	17	12
Income			
Under $15,000	66%	63%	74%
Over $15,000	19	23	14

(Refusals and "don't know" omitted)

Forty-seven percent of the women respondents were widows, and three fourths of the widows lived alone. One major indicator of the extreme age of the sample was the very large number of respondents who broke off in the middle of the interview. General experience and indeed our experience with the other two companies in this study, which had a younger age sample, shows this to be characteristic of the elderly.

Medicare and Blue Cross

More than three-fourths of the entire sample was covered by Medicare. Given the high average age, this is not surprising, but it is significant from the standpoint of coordination of benefits. Similarly, despite their age, two thirds of the sample were covered by Blue Cross/

Given this motivation structure of fear of cost coupled with the availability, the average respondent presumably should be concerned with the actual benefits the policy would pay if a high cost cancer attack should occur. Most respondents do not understand the amount of benefits of the Union Fidelity policy. When asked what part the policy would pay of a total hospital/doctors bill of $20,000, only about 5% of those who even knew they had cancer policies estimated less than half this amount, the more accurate amount. One quarter said they would receive all of the $20,000, and more than half admitted that they did not know. Given the normal payout of about 35%, it is clear that most respondents either grossly overestimated or had no idea what their policy benefits really are.

Respondents showed a similar lack of knowledge of specific policy conditions. For example, more than half of policyholders did not know if there was a time limit on benefits and the balance split evenly between "no time limit" and "yes, a time limit."

Other Union Fidelity policies

About one fifth of all respondents said they had a Union Fidelity policy other than a cancer policy, with 12% saying they had a Medicare supplement or similar policy. According to the sample records, about half of all respondents have such a policy, with the great majority having a Medicare supplement policy. Again, this discrepancy is probably connected to the advanced age of the respondents. We did not get enough respondents who knew of their other Union Fidelity policies to allow much detailed analysis, but the results we did obtain fit the same pattern as that for the cancer policy. For instance, policies were bought without agents on the basis of brochures with incidence and cost of the disease being the main motivators.

Claims

There were a very small minority of respondents who had made a claim. Within this small group, there was no evidence of dissatisfaction with the processing of their claim.

CONCLUSIONS

Union Fidelity sells cancer policies almost exclusively to elderly people through the mail by emphasizing the costs and financial burdens of cancer. This sales approach results in policyholders who have little knowledge of the actual benefits provided by Union Fidelity and who also have overlapping coverage with Blue Cross/Blue Shield and/or Medicare.

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TIME INTERVIEW BEGUN ______________________

INTERVIEW DESIGNATION: Page______ Line________ ______________

Hello, my name is __________. The Massachusetts Division of Insurance, the state agency which regulates and supervises insurance companies operating in the state, has asked us to interview people about their health insurance. If you wish, you may call Alan Wright at the Division of Insurance Chief Examiner's office (617) 727-4395 to confirm our credentials.

1. Are you personally covered by your own or someone else's Blue Cross/Blue Shield insurance policy?	1 YES 2 NO -- GO TO Q. 5 3 DON'T KNOW -- GO TO Q. ____
IF "YES", ASK: 2. Have you ever read your Blue Cross or Blue Shield policy or a description of its benefits?	1 YES 2 NO
3. Do you have any health insurance with any other companies in addition to Blue Cross/Blue Shield?	1 YES 2 NO 3 DON'T KNOW
IF "YES", ASK: 4. If you were to make a claim to both Blue Cross/Blue Shield and to this other insurance company for the same bill, as far as you know would Blue Cross/Blue Shield pay the bill, pay a reduced bill or not pay the bill at all?	1 PAY THE BILL 2 PAY A REDUCED BILL 3 NOT PAY AT ALL 4 DON'T KNOW
5. Are you personally covered by Federal Government medicare insurance?	1 YES 2 NO -- GO TO Q. 7 3 DON'T KNOW--GO TO Q. 7
IF "YES", ASK: 6. Have you ever read a description of your medicare insurance coverage?	1 YES 2 NO
7. Do you have any health insurance policies with the Union Fidelity Insurance Company?	1 YES-- GO TO Q. 10 2 NO 3 DON'T KNOW
IF "NO", ASK: 8. Have you ever had any health insurance policies with the Union Fidelity Insurance Company?	1 YES 2 NO -- GO TO Q. 10 3 DON'T KNOW --GO TO Q.1
IF "YES", ASK: 9. Was this policy cancelled by Union Fidelity, or did you drop the policy yourself?	1 CANCELLED BY COMPANY 2 DROPPED IT MYSELF 3 DON'T KNOW--GO TO Q.10

IF POLICY CANCELLED BY COMPANY, ASK:

9a. Why did the company cancel your policy?

IF POLICY DROPPED, ASK:

9b. Why did you drop this policy?

9c. When you dropped this policy, did you replace it with another policy?

ASK EVERYBODY.

10. Some insurance companies sell policies limited to covering expenses specifically resulting from cancer. Do you have or have you had a policy that only covers cancer expenses?

1 YES, NOW HAVE CANCER POLICY
2 YES, HAVE HAD CANCER POLICY
3 NO, HAVE NOT HAD CANCER POLICY -- GO TO Q. 40

IF YES, NOW HAVE OR HAVE HAD A CANCER POLICY, ASK:

11. How many policies that cover only cancer and no other illness do you presently have?

________ POLICIES
Y NONE--GO TO Q.40

12. What is the name of the company of your most recent (or only) cancer policy? (INTERVIEWER: PROBE FOR THE COMPLETE NAME, WRITE THE COMPLETE NAME BELOW.)

____

INTERVIEWER READ TO RESPONDENT: Now I am going to discuss this most recent cancer policy."

13. How did you hear of this most recent (or only) cancer policy--from an insurance agent you had dealt with before, from a new insurance agent, from a brochure that came in the mail, or from an advertisement?

1 AGENT DEALT WITH BEFORE
2 NEW INSURANCE AGENT
3 BROCHURE IN MAIL
4 ADVERTISEMENT
5 DON'T KNOW

IF BROCHURE IN MAIL OR "ADVERTISEMENT", ASK:

14. Did you ever discuss this cancer policy with an insurance agent?

1 YES -- GO TO Q.____
2 NO -- GO TO Q.____

IF RESPONDENT DEALT WITH AN AGENT ON THIS CANCER POLICY, ASK BELOW. ALL OTHERS GO TO Q. 26

15. What were some of the most important things the agent told you about why you need a policy that only covers cancer?

16. Did your agent mention to you that 1 out of 4 Americans will eventually get cancer?	1 YES 2 NO 3 DON'T KNOW
17. Did your agent mention to you that breast cancer strikes more women than any other form of cancer?	1 YES 2 NO 3 DON'T KNOW
18. About how many minutes or hours did your agent spend discussing this policy with you, either in person or on the phone?	1 LESS THAN 15 MINUTES 2 15 - 30 MINUTES 3 31 - 59 MINUTES 4 ONE HOUR 5 TWO HOURS 6 MORE THAN 2 HOURS 7 DON'T KNOW
19. Where did you first discuss this policy with your agent--in your home, where you work, or in the agent's office or was it on the telephone?	1 IN YOUR HOME 2 WHERE YOU WORK 3 IN AGENT'S OFFICE 4 ON TELEPHONE
20. Were any other members of your family present when your agent explained this cancer policy to you?	1 YES 2 NO
21. Did you discuss this cancer policy with friends or relatives before you agreed to purchase it?	1 YES 2 NO
22. Did you decide to purchase this cancer policy at the same time the agent spoke with you, or did you wait a few days to decide?	1 WHEN AGENT SPOKE TO ME 2 WAITED A FEW DAYS 3 OTHER ______ 4 DON'T KNOW
23. Thinking back to the time you discussed this cancer policy with your agent, did the agent try to sell you more than one policy at that time?	1 YES 2 NO 3 DON'T KNOW
24. How many other insurance policies did you buy at the same time you bought this cancer policy?	______ POLICIES X NONE Y DON'T KNOW

25. For how many months or years have you know the agent who sold you your cancer policy?	______ YEARS ______ MONTHS X LESS THAN ONE MONTH Y DON'T KNOW
25a. How often does this agent usually call on you. either personally or by telephone--about one a month, 3-4 times a year, once-twice a year, or less than once a year?	1 ONCE A MONTH 2 3-4 TIMES A YEAR 3 1-2 TIMES PER YEAR 4 LESS THAN ONCE A YEAR 5 DON'T KNOW

ASK EVERYBODY

26. Thinking of your most recent cancer policy, did you buy it to replace a former cancer policy, in addition to a former cancer policy, or is it a completely new cancer policy?	1 TO REPLACE FORMER POLICY 2 IN ADDITION TO 3 COMPLETELY NEW POLICY 4 OTHER ______ 5 DON'T KNOW

IF "REPLACED" OR "IN ADDITION TO", ASK:

27. How much influence did your agent have on your decision to replace a former policy or add another one--a great deal of influence, some influence, or very little influence?	1 A GREAT DEAL OF INFLUENCE 2 SOME INFLUENCE 3 VERY LITTLE INFLUENCE 4 DON'T KNOW
28. Thinking of your most recent cancer policy, have you ever seen or read a brochure describing the terms of this cancer policy?	1 YES 2 NO-- GO TO Q. 31 3 DON'T KNOW--GO TO Q.31

IF HAVE READ BROCHURE ABOUT POLICY, ASK:

29. What were some of the most important things the brochure told you about why you need a special policy just to cover cancer?

30. How much of the brochure have you read--all of it, about half of it, or less than half of it?

1 ALL OF IT
2 ABOUT HALF OF IT
3 LESS THAN HALF
4 NONE
5 DON'T KNOW

31. What are your most important reasons for buying a cancer insurance policy?

32. Thinking of your most recent (or your only) cancer policy, what made you especially choose that one rather than some other company's policy?

33. Thinking of your most recent (or your only) cancer policy, what is the maximum dollar amount this policy says it will pay you for an illness?

__________ DOLLARS
X DON'T KNOW
Y NO LIMIT

34. Thinking of your most recent (or only) cancer policy, when it says "hospitalization", which of these does hospitalization cover? (READ CATEGORIES BELOW)

1 Care in hospitals only
2 Care in nursing homes
3 Care in rest homes or extended care facilities
4 Care in all types of these facilities
5 OTHER ____________________
6 DON'T KNOW

35. Will this cancer policy pay your doctor's fees only when you are in a hospital, or when you are treated both inside or outside a hospital?

1 PAY ONLY WHEN HOSPITALIZ
2 PAY BOTH IN AND OUTSIDE OF HOSPITAL
3 DON'T KNOW

36. Is there any time limit on how long your cancer policy will pay benefits after you have been diagnosed as having cancer?

1 YES
2 NO
3 DON'T KNOW

37. Thinking of your most recent (or only) cancer policy, are you covered by the policy during the first 120 days that you own it?

1 YES
2 NO
3 DON'T KNOW

38. If you received a total hospital/doctor's bill for $20,000 from a cancer illness, about how much of this bill do you think your cancer insurance policy would pay for you -- all $20,000, between $10,000 and $20,000, or less than $10,000?

1 ALL $20,000
2 BETWEEN $10,000-$20,000
3 LESS THAN $10,000
4 DON'T KNOW

39. If you received a total hospital/doctor bill for $2,000 from a cancer illness, about how much of this bill do you think your cancer insurance policy would pay for you -- all $2,000, between $1,000 and $2,000, or less than $1,000?

1 ALL $2,000
2 BETWEEN $1,000 - $2,000
3 LESS THAN $1,000
4 DON'T KNOW

40. Do you have any other insurance policies with the Union Fidelity Insurance Company?

1 YES
2 NO -- GO TO Q. 57
3 DON'T KNOW--GO TO Q. 57

IF "YES", ASK:

41. I am going to read you a list of policies offered by Union Fidelity. For each type of policy, please tell me whether you own that policy.

	OWN IT	DO NOT OWN	DON'T KNOW
a) Medicare Cash Supplement	1	2	3
b) Medicare Supplement and Nursing Plan	1	2	3
c) Heart Attack Plan	1	2	3
d) Hospital Cash Plan	1	2	3
e) Lifetime Hospital Cash Plan	1	2	3
f) Supplementary Hospital Cash Plan	1	2	3
g) Medical/Surgical Cash Plan	1	2	3
h) Nursing Home Plan	1	2	3
i) Extended Care Nursing Home Plan	1	2	3
j) Wide Range Hospital/Surgical	1	2	3
k) Extra Protection Hospital/Surgical	1	2	3
l) Major Hospital Protection	1	2	3
m) Surgical Benefit Rider	1	2	3

IF DO NOT OWN ANY OF ABOVE POLICES, GO TO Q. 57, PAGE 9.

ALL QUESTIONS ON THIS PAGE REFER TO THE POLICY NEAREST THE TOP OF THE LIST ON PAGE 6 FIRST MENTIONED AS OWNED BY THE RESPONDENT. WRITE IN NAME OF THAT POLICY BELOW FOR YOUR REFERENCE THROUGHOUT THE FOLLOWING QUESTIONS.

42. Thinking of your (______________________) WRITE IN NAME HERE AND REFER TO IT policy, did you ever discuss this policy with an insurance agent?	1 YES 2 NO --GO TO Q. 48 3 DON'T KNOW--GO TO Q. 48

IF "YES", ASK:

44. For how many months or years have you known the agent who sold you your ______________ policy?	________ YEARS ________ MONTHS X LESS THAN ONE MONTH Y DON'T KNOW
45. How often does this agent usually call on you either personally or by telephone--about once a month, 3-4 times a year, once-twice a year, or less than once a year?	1 ONCE A MONTH 2 3-4 TIMES PER YEAR 3 1-2 TIMES PER YEAR 4 LESS THAN ONCE A YEAR 5 DON'T KNOW
46. Thinking back to the time you discussed this policy with your agent, did the agent try to sell you more than one policy at that time?	1 YES 2 NO 3 DON'T KNOW

48. How many other (NAME OF POLICY) do you have with any other insurance company besides Union Fidelity?	________ POLICIES X NONE Y DON'T KNOW
49. Thinking of your present (NAME OF POLICY) did you buy it to replace a similar policy, in addition to a similar policy, or is it a completely new policy?	1 TO REPLACE A SIMILAR ONE 2 IN ADDITION TO 3 COMPLETELY NEW POLICY 4 DON'T KNOW

IF "REPLACED" OR "IN ADDITION TO", ASK:

50. How much influence did your agent have on your decision to replace a similar policy or add another one--a great deal of influence, some influence, or very little influence?	1 A GREAT DEAL OF INFLUENCE 2 SOME INFLUENCE 3 VERY LITTLE INFLUENCE 4 DON'T KNOW
51. Did you buy any other insurance policies at the same time you bought your (NAME OF POLICY)?	1 YES 2 NO 3 DON'T KNOW
52. Thinking of your (NAME OF POLICY) have you ever seen or read a brochure describing the terms of this policy?	1 YES 2 NO--GO TO Q. 55 3 DON'T KNOW--GO TO Q. 55

IF HAVE READ BROCHURE ABOUT POLICY, ASK:

53. What were some of the most important things the brochure told you about why you need this type of special policy?	
54. How much of the brochure have you read--all of it, about half of it, or less than half of it?	1 ALL OF IT 2 ABOUT HALF OF IT 3 LESS THAN HALF 4 NONE 5 DON'T KNOW
55. What are your most important reasons for buying (NAME OF POLICY)?	
56. Thinking of your (NAME OF POLICY), what made you especially choose that one rather than some other company's policy?	
57. Have you ever made a claim under a policy that covered only cancer expenses?	1 YES -- GO TO Q. 59 2 NO
58. Have you ever made a claim under (NAME OF POLICY) against Union Fidelity Insurance Company?	1 YES 2 NO 3 DON'T KNOW

IF RESPONDENT MADE A CLAIM IN Q. 57, or Q. 58, ASK: ALL OTHERS GO TO Q. 65

59. Was the claim paid in full, paid partially, denied, or is the claim still in process?	1 PAID IN FULL 2 PAID PARTIALLY 3 DENIED 4 IN PROCESS 5 OTHER ____________
60. How much was your total claim to the insurance company?	$__________ Y DON'T KNOW
61. How much money did the insurance company pay you?	$__________ Y DON'T KNOW
62. Was this payment more than you expected, was it less than expected, or was it about what you expected?	1 MORE THAN EXPECTED 2 LESS THAN EXPECTED 3 ABOUT WHAT EXPECTED 4 DON'T KNOW
63. Did you also receive money from any other insurance company for the same illness?	1 YES 2 NO 3 DON'T KNOW

64. Was the claim you submitted greater than your actual bills, less than your actual bills, or the same as your actual bills?

1 GREATER THAN
2 LESS THAN
3 SAME AS
4 DON'T KNOW

Now, I have a few questions for statistical purposes . . .

65. How old are you?

__________ YEARS

66. What was the last grade you completed in school?

1 HIGH SCHOOL INCOMPLETE
2 HIGH SCHOOL COMPLETE
3 SOME COLLEGE
4 COLLEGE COMPLETE

67. What is your marital status?

1 MARRIED
2 SINGLE, NEVER MARRIED
3 DIVORCED
4 WIDOWED
5 SEPARATED

68. How many people over age 18 live in your household, including yourself?

1 ONE
2 TWO
3 THREE
4 FOUR OR MORE

69. What is your ethnic background? PROBE: Are you descended from Irish immigrants, etc?

1 IRISH, ENGLISH, WELSH, SCOTS
2 ITALIAN
3 EASTERN EUROPEAN (POLISH, HUNGARIAN, CZECH)
4 JEWISH
5 GERMAN, AUSTRIAN
6 SCANDINAVIAN (DANISH, NORWEGIAN, FINN, SWEDE)
7 FRENCH
8 SPANISH SPEAKING (PUERTO RICAN, CUBAN, ETC.)
9 ORIENTAL
10 BLACK (AFRICAN)
11 OTHER ____

70. How many full-time wage earners live in this household, including yourself?

1 NONE
2 ONE
3 TWO
4 THREE OR MORE

IF ANY FULL-TIME WAGE EARNER, ASK:

71. Are you covered by any group health insurance paid in full or in part by the employer?

1 YES
2 NO
3 DON'T KNOW

72. Have you ever bought any insurance sold through this employer, but not paid for by the employer?

1 YES
2 NO
3 DON'T KNOW

73. Is your total family income under $15,000 per year, between $15,000 - $25,000 per year, or more than $25,000 per year?

1 UNDER $15,000
2 $15,000 - $25,000
3 MORE THAN $25,000

4. SEX: 1 MALE 2 FEMALE

75. Has anyone in your immediate family or among your friends had any form of diagnosed cancer within the past five years?

1 YES
2 NO
3 DON'T KNOW

THANK YOUR FOR THIS INTERVIEW !

TIME INTERVIEW ENDED ____________________ LENGTH OF INTERVIEW ____________

INTERVIEWER'S NAME ____

INTERVIEWER EVALUATION:

76. The respondent:

1 SPOKE ENGLISH VERY WELL
2 SPOKE ENGLISH ADEQUATELY
3 SPOKE ENGLISH POORLY

77. The respondent

1 SEEMED TO UNDERSTAND ALL QUESTIONS VERY WELL
2 SEEMED TO UNDERSTAND MOST QUESTIONS
3 SEEMED TO UNDERSTAND FEWER THAN HALF THE QUESTS.
4 SEEMED TO UNDERSTAND ONLY A FEW OF THE QUESTS.

Market Conduct Examination Report
# of the
Washington National Insurance Company

1978

ENSE PETIT PLACIDAM SUB LIBERTATE QUIETEM

Division of Insurance
Commonwealth of Massachusetts

The Commonwealth of Massachusetts
Division of Insurance
100 Cambridge Street, Boston 02202

NAIC Market Conduct Examination
Subcommittee
The Honorable Richard L. Block
Director of Insurance
State Office Building
Juneau, Alaska 99881

The Honorable Richard L. Mathias
Director of Insurance
160 N. Lasalle St., Room 1600
Chicago, Illinois 60601

The Honorable Stephen F. Clifford
Commissioner of Insurance
100 Cambridge Street
Boston, Massachusetts 02202

Dear Commissioners:

At the request of The Commonwealth we have conducted a limited market conduct examination of Washington National Insurance Company ("Company") of Evanston, Illinois as at December 31, 1977 and of certain items relating to subsequent periods.

The Washington National Insurance Company is an Illinois domiciled insurance company transacting accident and health and life insurance in its own or a subsidiary's name in every state under a general agency system. The Company's admitted assets and premium income at and for the year ended December 31, 1977 is $795,337,742 and $352,792,939, respectively. The premium income for the year ended December 31, 1977 in Massachusetts amounted to $3,754,745.

The examination team was comprised of representatives from Coopers & Lybrand who addressed those areas which required accounting expertise and Mr. Paul Gitlin, Esquire who addressed those areas which required legal expertise. The team coordinated their work and findings under the supervision of members of the staff of the Massachusetts Insurance Division.

Our examination was directed primarily to company issued Dread Disease Policies, which are marketed in the Commonwealth of Massachusetts through one representative of the Company under sponsorship of newspapers or motor clubs. It was intended that we would also review Medicate Supplement types of coverage but our inquiry disclosed that such coverage is not currently offered by the Company.

The scope of our examination was dictated by a Special Market Conduct Program ("SMC Program") and included requesting and receiving the following from the Company:

A. Listings of current Massachusetts agents and the company's files on terminated agents for the period January 1, 1977 to June 30, 1978.

B. Copies of the Company's prenumbered multi-parts form to log in complaints from insured and the Company's file of complaints, claimants, Insurance Departments, or other sources for the period January 1, 1977 through August, 1978.

C. A copy of cancer expense policy form number NA 1045c and all marketing material incident to its sale.

D. A copy of the application form utilized by the Company in the issuance of the cancer expense policy.

E. A statutory annual statement for the year ended December 31, 1977

Listings of:

F. Teachers Group Accident and Health Paid Claims during the period January 1, 1977 to June 30, 1978.

G. Accident and Health Group Marketed Paid Claims during the period June 1, 1977 to June 30, 1978.

H. Credit Union and Teachers Industrial Accident and Health Paid Claims during the period January 1, 1977 to June 30, 1978.

I. Ordinary Life Insurance Policies in force of Massachusetts residents as of June 30, 1978.

J. Insurance in force Policyholders for The Boston Globe account as of June 30, 1978.

K. Insurance in force Policyholders for Telegrams and Gazette account as of June 30, 1978.

L. Insurance in force Policyholders for Patriot Ledger account as of June 30, 1978.

M. Claims Paid June 1, 1977 to June 30, 1978 for account of Newspapers (J K & L above) and Auto Clubs.

N. Individual Accident and Health Guaranteed Renewable Massachusetts Policyholders as of June 30, 1978.

O. Group Industrial and Teachers Premiums for the period January 1, 1977 to June 30, 1978.

P. Policy forms issued in Massachusetts.

Q. Source of statistics used in brochures on cancer expense policies sold in Massachusetts.

R. Date of enrollment periods for sale of cancer expense policies.

S. Schedule of commission rates based on paid premium for Newspaper and Auto Club sponsored insurance solicitations.

With respect to each of the above, we read the documents and formulated questions, and completed the appropriate sections of the SHC Program applicable to such items. Additionally for each item specifically described below, we have listed our findings which require your consideration.

Findings and Recommendations

A. Terminated Agent's

There were no agents terminated during the period of review who were involved with the sale of the Company's cancer expense policy. The most prevalent reason for terminating agents appeared to be an insufficient volume of business written. One agent also issued checks without sufficient funds in his account in payment of business written.

Although the Company has a form on which the reason for an agents termination is to be indicated and the form then filed in the agents folder, such forms were not always in evidence. Further, the reason for termination when the form was in evidence was not always clear.

We recommend that the Company ensure that its prescribed procedures and practices are followed and that the reasons for termination of agents be clearly indicated.

B. Review of Complaint Files and the Company's Complaint Follow-up System

We noted instances in which the complaint files did not:

1. Include all pertinent correspondence and material regarding the complaint.
2. Acknowledge the complaint within the time frame established by the Company.
3. Outline the present status of the complaint.
4. Indicate action taken to prevent or reduce similar justified complaints in the future.
5. Answer the direct question in the complaint.

We recommend that the Company establish procedures to ensure that:

A. All "complaint" type files are all-inclusive, that is, that they include all correspondence from the insured, agents, and the Company.

B. Complaint files are periodically reviewed by a responsible individual independent of the department to which the complaint pertained.

C. General Agent's and sub agent's correspondence is also included in the file and that independent verification of follow-up should be performed by the Company and documented within the file.

D. The Company has a monthly report which includes a log listing all complaints, the number of days after receipt of the compliant that the first and then the final responses have been sent the insured. Further the Company should establish a procedure which sends a final letter to all insureds who had issued a complaint.

In April 1978 the Company's complaint follow-up system revised to establish central control over the complaint system in the person of the Company's Public Affairs Manager. At the time of our review sufficient time had not elapsed to evaluate the effectiveness of the revised system, however items A and C above do not appear to be properly considered within this new system.

C. Cancer Expense Policy Marketing Material

The Company's cancer expense policy is sold through the sponsorship of and to members of the Tri-County Auto Club of Holyoke, Massachusetts (an affiliate of the American Automobile Association). The marketing methods used by the Company and the documents produced appear to violate numerous Massachusetts statutes including Massachusetts General Laws (M.G.L.):

c.175, §110E
c.176D, §11
c.93A, §2(a), as follows:

1. The marketing materials did not contain information concerning the average financial cost of the treatment of cancer. Without such data it is impossible to determine if the policy benefits available are worth the premiums charged.

   The failure to disclose the average financial cost of cancer appear to violate M.G.L.:

   c.176D, §11 Regulation 5 and 6

   c.175, §110E Regulation (1-74) 5A and 6

   c.93A, §2

   because this disclosure, if made, might influence a prospective buyer to seek alternative insurance coverage.

2. The marketing methods used misrepresent the effect of other insurance policies on the consumers retention of benefits provided since the material stressed that the cancer coverage will pay expense benefits regardless of the existence of other insurance. While that representation is technically true, it is nevertheless misleading because it fails to inform the consumer that there exists a very real possibility in Massachusetts that the benefits provided by this policy will reduce any benefits expected from the consumers other insurance policies; such as, Blue Cross/Blue Shield.

   The misrepresentation of the effect of overlapping insurance coverage appear to violate M.G.L.:

   c.176D, §11, Regulation 5
   c.175, §110E, Regulation (1-74) 5
   §93A, §2

because it has the tendency to mislead the public about the extent of insurance proceeds reasonably expected to be paid.

The effect of other insurance companies coinsurance or coordination of benefit provisions should be clearly disclosed. The language promoting the fact that money will be paid regardless of the existence of other insurance should be stricken. The marketing material is not sufficiently clear and complete to avoid deception or the capacity to mislead or deceive.

3. While the material contains numerous examples of unclear or incomplete assertions, the most critical concerns the disclosure of the policy's exemption provision. This provision is written in such a way that repeated readings are required to understand it.

   The use of unclear language appears to violate M.G.L.:

   c.176D, §11, Regulation 5;
   c.175, §110E, Regulation (1-74) 5;
   c.93A, §2

   because it has the capacity to mislead or deceive.

   Those segments of the promotional material that are difficult to understand should be redrafted. Special attention should be paid to the exemption provision so that this important policy limitation is clearly understood.

4. Another example of unclear or incomplete statements involves the longevity of the insurance coverage. The policy is promoted as one that will continue for as long as premiums are paid, membership in the sponsoring organization continues, and the "master policy" is in effect. The overall impression is created that the circumstances of policy termination are fundamentally under the control of the consumer. This is not true because the "master policy" is nothing other than a restatement of the individual policy with one major exception - it is cancellable by either party upon sixty days notice, prior to the anniversary date of the policy.

This use of incomplete information creates an improper impression of the cancellability of the coverage and therefore appears to violate M.G.L.:

c.176D, §11, Regulation 5;
c.175, §110E, Regulation (1-74) 5;
c.93A, §2

The effect of the contractual relationship between the insurance company and the sponsoring organization on the possibilities of renewal should be clarified.

5. The Company uses misleading statements and omits additional information concerning the benefits provided which misleads or has the capacity to mislead purchasers about the extent of the benefits payable.

The promotional letter announcing the availability of this insurance coverage which is sent on AAA stationery, but is prepared by the Company, claims that the plan provides substantial benefits. Whether the benefits are in fact substantial depends on their relationship to the total costs an insured can expect to incur. No information is provided to a prospective purchaser about the costs expected if he/she is inflicted with the disease. In addition, the schedule of benefits shows payment levels for specific medical/surgical procedures far below the actual expected costs of those procedures. The letter also claims that an insured will receive a special $75,000 benefit provision for extended hospital stays. In fact, the total aggregate allowable benefit under the policy is $75,000. This maximum includes all benefits paid before the extended benefit provision is triggered (91st consecutive day of hospitalization), and also includes benefits paid under circumstances requiring multiple extended hospitalizations.

The promotional material mistates or misleads consumers concerning the extent of benefits provided and therefore appears to violate M.G.L.:

c.176D, §11, Regulation 6A;
c.175, §110E, Regulation (1-74) 6;
c.93A, §2

6. The company fails to specifically inform the prospective purchaser that the policy covers cancer only. Although the material states that the policy is a cancer expense policy, there is no indication, other than in the confusingly drafted exemption provision, that the policy coverage is limited to costs incurred as a result of cancer.

   The failure to conspicuously state the limited nature of the policy appears to constitute a violation of M.G.L.:

   c.176D, §11, Regulation 6A(9);
   c.175, §110E, Regulation (1-74) 6A(7);
   c.93A, §2

7. The Company's brochure is replete with facts and figures concerning cancer. The inclusion of this otherwise superfluous information creates an emotional atmosphere of concern about contracting the disease. Insurance purchases should be contemplated and made for functional reasons, and not as a result of an artifically created fear of being inflicted with a particular malady. The infusion of this information has the effect of concentrating the consumer's attention on the disease and may trigger purely emotional responses to the purchaser's innate fear of cancer.

   The creation of a climate whereby the insurance purchase is made for emotional rather than functional reasons appears to violate M.G.L.:

   c.176D, §11, Regulation 6A(11);
   c.93A, §2

8. The exception provision language employed by the Company effectively establishes a thirty day waiting period, but the company in its promotional materials fails to clearly disclose the existence of this waiting period. The coverage under this policy includes only cancer first diagnosed after the expiration of thirty days from the effective date of the individual insurance contract. This creates a thirty day waiting period, which is not disclosed as such in the promotional material.

   The failure to disclose the existence and extent of the waiting period appears to constitute a violation of M.G.L.:

   c.176D, §11, Regulation 6B(2);
   c.175, §110E, Regulation (1-74) 6B(2);
   c.93A, §2

9. The documents do not contain a clear explanation of the cancellation, termination or renewal provision. The continuation of this policy is contingent on the continuation of the relationship between the company and the sponsoring organization. Either of these parties may cancel their contract with sixty days notice. This possible basis for termination is discussed in a question and answer section on the back page of the major promotional booklet, but the explanation creates a faulty impression of the actual relationship of the parties. (See Section 4 above)

   The failure to clearly disclose the full extent of the cancellation, termination or renewal policy appears to violate M.G.L.:

   c.176D, §11, Regulation 8;
   c.175, §110E, Regulation (1-74) 7;
   c.93A, §2

   The actual relationship between the Company and the sponsoring organization, and the effect of this relationship on the possibility of termination of the individual policy should be clearly disclosed.

10. The marketing method used implies that the insurance plan is approved or endorsed by AAA, without disclosing the financial consideration they received from the company. The letter sent by the local AAA affiliates to its membership implies that this organization endorses this insurance product. In fact the local organization receives compensation in the form of a percentage of premiums collected.

   The failure to disclose the financial relationship between the insurance company and the sponsoring organization while at the same time implying an endorsement of the product by this organization appears to violate M.G.L.:

   c.176D, §11, Regulation 9C;
   c.175, §110E, Regulation (1-74) 8C;
   c.93A §2

11. Company has used a substantial number of statistical references and statements derived from American Cancer Society publications. Not only does the company fail to identify the source (the American Cancer Society has asked the company not to use its name), but many of the references and statements are outdated. For example, the brochure contains an ascertain that "cancer is on the increase", but the most recent American Cancer Society report indicates that the overall incidence of cancer has decreased slightly in the last twenty-five years, and that the death rate has been leveling or dropping (depending on the type of cancer).

    The use of statistical information without reference to its source appears to violate M.G.L.:

    c.176D, §11, Regulation 10C;
    c.175, §110E, Regulation (1-74) 9C;
    c.93A §2

    The use of outdated and misleading statistics appears to violate M.G.L.:

    c.176D, §11, Regulation 5;
    c.175, §110E, Regulation (1-74) 5B and 6A

12. The documents fail to identify the form number of the policy.

    The failure to include the form number of the policy being promoted appears to constitute a violation of M.G.L.:

    c.176D, §11, Regulation 14A

13. The policy is marketed as a group policy when in fact it fails to meet the traditional tests for group policies. The name of the policy, AAA Group Cancer Expense Insurance Policy, the marketing methods, and the normal interpretation of statements used to promote the policy imply that the insurance offered is a "group policy." In fact, the policies issued are sold to individuals, and these individuals bear the total responsibility for premium payments. This policy should be characterized as a "franchise policy."

Although the Company claims that the existence of the group results in lower premium obligations for the members, the fact that the Company engages in absolutely no underwriting analysis in writing these policies argue against this contention. In addition, the company claims that non-affiliated individuals would have to pay a higher premium, but admits that it does not sell this policy to non-affiliated individuals.

The practice of implying a group status when such is not the case appears to violate M.G.L.:

c.176D, §11, Regulation 15;
c.175, §110E, Regulation (1-74) 14;
c.93A, §2

The implication that this policy constitutes a group plan should be prohibited and the true characterization should be used.

14. The commissions paid on this policy are paid to an organization which is not a licensed Massachusetts insurance broker. The Tri-County Auto Club receives a payment of 17.5% on the premiums paid by its members to the Company. The Company claims that this is an administrative fee, but the Auto Club does not engage in any meaningful administrative duties. In addition, the practice of basing payments on the amount of money collected is in keeping with the concept of "commission" and not with the concept of "administration."

The payment of commissions on sales of insurance to nonlicensed individuals appears to violate M.G.L.:

c.175, §177;
c.176D, §11

The practice of paying commissions to unlicensed individuals should be curtailed.

D. Cancer Expense Application Form

1. The Company's application form for cancer expense policies excludes certain required information and accordingly violates numerous Massachusetts statutes including MGL:

   c.176D, §11

   c.175, §110E, as follows:

   c.93A, §2

   Although the benefits recoverable represent less that 50% of the cost of an average hospital stay, the application does not contain required statement that "this policy is supplemental in its coverage and is meant to be purchased in addition to basic health insurance. This policy pays for ______% of the cost of an average stay in a Massachusetts Hospital as defined by the Massachusetts Division of Insurance Hospital Cost Standards."

   Calculation of the proportionate maximum payments per average stays in Massachusetts hospitals indicates that this policy will pay 23% of the cost of a short stay, 49% of an average stay, and 46% of a long stay. Since the payments possible do not exceed 50% of the average costs for these standard periods of hospitalization, the consumer should be informed of this fact so that additional coverage can be purchased.

   The Company's failure to include the required percentage reimbursement information on the application appears to constitute a violation of M.G.L.:

   c.176D, §11, Regulation 6A(3) and 7A

   c.93A, §2

2. The application fails to clearly and unambiguously disclose the Company's pre-existing condition exclusion provision. The only semblance of a disclosure concerning the pre-existing condition exclusion is found in a question asked on the application. This question concerns whether any person to be covered under the policy has or has ever had cancer. The last part of this underwriting question indicates that any persons named will not be covered. While this procedure introduces the concept of the exclusion, it is neither a clear nor a complete statement of the Company's exclusion policy.

The failure to include a clear and unbiguous statement of the Company's pre-existing condition exclusion in the application appears to constitute a violation of M.G.L.:

c.176D, §11, Regulation 7B;
c.175, §110E, Regulation (1-74) 6C(3)
c.93A, §2

3. The application fails to contain any of the additional information required by Massachusetts Insurance Division regulations. The application form is a very simple envelope size document containing almost no information. In addition to its failure to include the information described above in this report, the company fails to disclose: the existence and extent of the waiting period; the fact that the reception of some benefits are contingent on hospitalization; the annual premium rate (the semi-annual rate is disclosed, but the more economic, annual rate is not); and the terms of renewability and premium guarantee; there is also no room provided on the application for the applicant's signature indicating that he/she understands the required disclosures.

The failure to disclose this information appears to constitute the following violations of M.G.L.:

c.176D, §11, Regulation 7C, 7D, 7E, 7F and 7G;
c.93A, §2

The failure to include and disclose that a cheaper premium rate is available appears to constitute a violation of M.G.L.:

c.176D, §11, Regulation 5A and 6A(1);
c.175, §110E, Regulation (1-74) 5A and 6A(1);
c.93A, §2

4. The application does not contain questions that elicit information concerning whether the insurance sought replaces other accident and sickness insurance. Massachusetts Insurance Division regulations require that a specific disclosure must be made if a consumer is replacing present coverage by purchasing a new policy. To effectuate this disclosure, the regulation also requires that any application ask questions designed to elicit this information.

The failure to include questions designed to elicit this information appears to constitute a violation of M.G.L.:

c.175, §110E, Regulation (2-74) 23(1)

E. Cancer Expense Policy Form

The following problems were found to exist in the cancer expense policy form utilized by the Company. For the purpose of this review, we assumed that the cancer policy, marketed in Massachusetts, creates and evidences an individual insurance relationship with the policyholder.

1. The policy does not contain a "Pre-existing condition provision" on the first page. The insurance provided covers expenses incurred for treatment of cancer which first manifests itself after the first thirty days of coverage. Thus, cancer is a pre-existing condition excluded under the policy, but the disclosure of this fact is not labeled "pre-existing condition provision" nor is it placed on the first page of the policy.

   The failure to correctly label and disclose the pre-existing condition exclusion appears to violate M.G.L.:

   c.175, §110E, Regulation (2-74) 5(19)

   The exemption provision should be labeled "Pre-existing condition provision" and should appear on the first page of the policy.

2. The pre-existing condition test used is not reasonable. The policy exemption provision excludes cancer first manifest prior to the 31st day of coverage. Since the initial manifestation of cancer often produces no discernable symptoms, the ordinarily prudent person might not know at the time of contracting with the Company that the costs he incurs would be excluded from coverage.

   The use of a test for pre-existing conditions other than one that would cause the ordinarily prudent person to seek medical assistance appears to violate M.G.L.:

   c.175, §110E, Regulation (2-74) 5(20)

3. The policy and the promotional material employ different standards for pre-existing condition exclusions. The promotional material states that cancer first manifest and diagnosed prior to the first 31 days of coverage is excluded. The policy exclusion provision requires only that the disease was manifest. The differences are substantial since cancers manifest months or years before diagnosable symptoms appear.

The use of a more restrictive exclusion in the policy than the one disclosed in the marketing material appears to constitute a violation of M.G.L.:

c.175, §110E, Regulation (1-74) 5E,
6A(1), (3) and (6), and 6C(1)
c.176D, §11, Regulation 5B, 6A(1) and (8)
and 6C(1)
c.93A, §2

4. Room and board daily benefits for 60 continuing days of hospital confinement are not equal to the cost of a semi-private room. The policy provides payment of $60 per day for the first 12 days of hospital confinement and $30 per day thereafter. This level of reimbursement does not equal the average Massachusetts rate for a semi-private room.

   The use of internal limits on dollar benefits which do not equal the cost of semi-private room appears to violate M.G.L.:

   c.175, §110E, Regulation (2-74) 5(31(a))

5. The policy is cancellable during the life of the insured, and the premiums may be increased. Although the material creates an impression that the policy is noncancellable as long as premiums are paid, the insurance coverage can be terminated by cancelling the contract between the Company and the sponsoring organization. The policy allows for a change in premium rates by reserving that right.

   Selling a specified disease policy which is cancellable during the lifetime of the insured and for which premiums may increase appears to be a violation of M.G.L.:

   c.175, §110E, Regulation (2-74) 5(32)

6. The Company does not utilize the required disclosure form.

   The failure to utilize the required form appears to violate M.G.L.:

   c.175, §110E, Regulation (2-74) 14

General Comment:

The violations pointed out in this report must be corrected and the recommendations implemented. The Company will submit to the Division of Insurance within sixty days of publication date of this examination report, a report stating how these violations have been corrected and recommendations implemented. New cancer expense policy and application forms and related promotional material must also be submitted within sixty days. The Legal Bureau of the Division of Insurance will consider the institution of disciplinary proceedings where appropriate.

* * * * * * * * * * *

In the course of our examination, we observed that a number of additional policy forms are marketed in The Commonwealth of Massachusetts utilizing marketing methods similar to those used in promoting the cancer expense policy. While the parameters of our examination did not allow an in depth analysis of the form and content of these policies, the examination team has observed that many of the problems described above may also be present in the marketing of these additional policies.

* * * * * * * * * * *

Very truly yours,

Coopers & Lybrand

Alan S. Wright
Chief Examiner

Coopers & Lybrand

Paul G. Gitlin, Esq.

Washington
National
INSURANCE COMPANY

[illegible]

November 27, 1978

Alan J. Wright
Acting Deputy Commissioner
Massachusetts Division of Insurance
110 Cambridge Street
Boston, Massachusetts 02202

Dear Mr. Wright:

The purpose of this letter is to state Washington National's position regarding the Massachusetts Division of Insurance Report on its Market Conduct Examination of Washington National, particularly the portion relating to the Tri-County Auto Club policy.

Many of the supposed violations cited in the Report stem from the supposition that the Tri-County Auto Club policy is an individual rather than a group policy. We maintain that this policy is indeed a group policy. MGL Ch. 175, Sec. 110, defines such policies:

> Ch. 175, Sec. 110. General or blanket policies; power to issue; non-applicability of Section 108.
>
> (A) Nothing in Section One Hundred and Eight shall be construed to apply to or affect or prohibit the issue of any general or blanket policy of insurance to . . . (f) any automobile club . . .

The section goes on to define a general or blanket policy of insurance:

> A policy on which premiums are paid by the policyholder, either partly from the employer's funds or funds contributed by him and partly by funds contributed by the insured employees, or wholly from funds contributed by the insured employees, . . . shall be deemed a blanket or general policy within the meaning of this section.

By analogy Washington National's Tri-County Auto Club policy fits within this definition. The payment of the entire premium by the insureds under the Auto Club policy does not, we submit, make this an individual rather than a group policy.

The usual criteria for groups eligible for group insurance are the following:

1. The group must be one formed primarily for some purpose other than obtaining the insurance.
2. There should be a relatively steady flow of new members into the group.
3. The individual is not permitted to select the amount of insurance he takes.

One authority states that "Members of labor unions, as well as associations of employers and members of other associations, also constitute qualified groups for health insurance under the laws of most states." J. Greider and W. Beadles, Principles of Life Insurance, Vol. I at 344.

By all these criteria the Tri-County Auto Club qualifies for the group policy which was issued to it.

The following are statements of our position relating to the various allegations of specific violations in the Report:

> C.1. The promotional literature states that this Cancer Insurance provides "additional insurance protection." It is clearly intended only to supplement general, non-specific, health coverages.
>
> The premiums charged for the Tri-County Cancer policy relate only to the benefits provided by that policy. We submit that the average cost of having cancer does not bear on whether or not the benefits under this policy are fair in relation to the premiums paid.
>
> C.2. Coinsurance and coordination of benefits provisions in other insurance policies obtained by the insured will be disclosed in those policies. Moreover, it is impossible for us to know what coinsurance or coordination of benefits provisions any such policies might contain. We maintain that to discuss the possible provisions of insurance policies which might be owned by a prospective insured would lead to confusion and in itself be misleading.

We deny that our failure to do so is a violation of the cited regulations.

C.3. The "Exceptions to Coverage" paragraph in the advertising material is composed of three fairly short sentences. It is our position that the sentences are intelligible to the average reader.

C.4. We maintain that the statement that the coverage will terminate when the master policy terminates clearly indicates that control of termination is not solely in the hands of the insured. We deny that this is "incomplete" information. The "Answers to Important Questions" section explains that coverage is contingent on the continuation of the "Club Master Policy." The letter states that an insured can retain insurance "as long as our Club's group policy remains in effect."

C.5. We maintain that there is no deception as to the "amount of benefits payable." We would argue that that the words "substantial benefits" not necessarily relate to the total amount of expenses an insured may incur. Surely no one would deny that $75,000 in benefits is a "substantial" amount.

"Expected" costs of hospital confinement vary widely for individuals, types of illness, duration of illness and location. Moreover, they have changed rapidly over time. We maintain that it would, in fact, mislead prospective insureds if we were to attempt to state these in the literature.

C.6. We maintain that the clear statement that the group master policy is a "Cancer Expense Policy" is sufficient to inform prospective purchasers that it covers only cancer.

C.7. The facts and figures concerning cancer are merely informative. Rather than inciting fear, the brochure states that "through early detection and treatment almost 50% of cancer victims could be saved." The purpose of this section is to induce readers to seek early detection and to avoid cancer-causing agents, such as smoking and excessive sun. We maintain that none of this material is exaggerated in the manner contemplated by 176D, Sec. 11, Regulation 6A(11).

C.8 The 30-day waiting period is disclosed in the brochure under "Exceptions to Coverage," and again under "Answers to Important Questions." It is also disclosed in Paragraph Six of the cover letter.

We, therefore, maintain that the literature is not in violation of the cited regulations.

C.9. (See Section C.4.)

C.10. 176D, Section 11, Regulation 9c, states that approval by an association shall not be stated or implied unless such is a fact. Unquestionably, the Tri-State Auto Club does approve and endorse the policy since the Club is the policyholder. There is no "proprietary or other financial relationship" between Washington National and the AAA Tri-County Auto Club, except for payment for administrative work delegated to the Club by Washington National. This would not seem to be the type of proprietary or other financial relationship meant by the regulation.

C.11. The brochure in question is an old, outdated one which has not been used for two years. Washington National plans to make changes in it before it is used again. It has not been established that the brochure was prepared and distributed after the release of the most recent American Cancer Society report. Moreover, in a recent newspaper article, OSHA indicated that cancer *is* on the increase.

C.12. The form numbers do seem to be missing, but the insurer and policy are clearly identified. It is difficult to see how a prospective insured could be misled as to what insurance he was buying.

C.13. We maintain that this policy meets all the traditional tests of a group policy as stated above. No policies are sold to individuals. Rather, certificates are issued to them. This entire arrangement is common in group insurance, including the market aspect.

C.14. We deny that commissions, rather than administrative fees are being paid to the Tri-County Auto Club. It is irrelevant that administrative fees are based on premium amounts. Premium amounts are directly related to the number of insureds and hence to the administrative duties involved.

D.1. The regulations cited are aimed at individual rather than group insurance, since they speak of marketing *policies* to insureds. We would, therefore, deny that we are in violation here, since an insurer could reasonably believe this regulation did not apply to group enrollment applications.

D.2. Here, again, an insurer could reasonably believe that the regulations cited were aimed at individual rather than group insurance.

D.3. (See Section D.2.)

D.4. 175, Sec. 110E, Regulation (2-74) 23(i) is aimed at individual policies (See Section 1, Purpose).

E.1-6 We again state our position that this policy meets the criteria for a group, rather than an individual, policy.

Sincerely,

Muriel L Crawford

Muriel L. Crawford

MLC:lrl

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